Supreme Court, U.S.
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No.

In The
Supreme Court of the United States

VANESSA WELSHANS and
PEGGY WELSHANS WILLIAMSON,
Petitioners,

v.

AETNA LIFE INSURANCE COMPANY,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

PETITION FOR WRIT OF CERTIORARI

LAWRENCE W. JACKSON
Counsel of Record
RIEVES, RUBENS & MAYTON
P.O. BOX 1359
304 EAST BROADWAY
WEST MEMPHIS, AR 72303
(870) 735-3420

KATHLEEN G. MORRIS
P.O. BOX 128091
42 RUTLEDGE STREET
NASHVILLE, TN 37210
(615) 320-8899

Attorneys for Petitioners

October 10, 2007

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

QUESTION PRESENTED FOR REVIEW

When jurisdiction in a federal court is founded solely upon diversity of citizenship, 28 U.S.C. § 1332 can a federal district court exercise jurisdiction over the cause of action by aggregating the claims and aggregating possible attorneys fees when the plaintiffs' prayer for relief specifically limits the request for judgment to $74,999.00 plus interest and costs?

LIST OF ALL PARTIES

Petitioners are:

Peggy Welshans Williamson and Vanessa Welshans.

The respondent is:

Aetna Life Insurance Company.

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OPINIONS AND ORDERS ENTERED

The orders and opinions of the United States District Court for the Western District of Tennessee, Western Division in case number 04-2851B have not been published in any official or unofficial reporters.

The Sixth Circuit's original decision on the merits can be found at:

Williamson v. Aetna Life Insurance Company, 481 F.3d 369, 2007 U.S.App.LEXIS 6597, 2007 FED. App. 0109P (6th Cir. 2007).

The unofficial citation to the Sixth Circuit's denial of petitioner's request for *en banc* rehearing can be found at:

Williamson v. Aetna Life Insurance Company, 2007 U.S. App. LEXIS 16860 (6th Cir. 2007).

BASIS FOR JURISDICTION

The United States Court of Appeals for the Sixth Circuit initially decided the issues presented by this petition for writ of certiorari in an opinion issued and filed on March 22, 2007. (Appendix 3a-23a) Petitioners then timely sought rehearing, and the petition for rehearing was denied by the United States Court of Appeals for the Sixth Circuit on July 12, 2007. (Appendix 1a-2a)

Petitioners believe that this court has jurisdiction to review the decision of the United States Court of Appeals for the Sixth Circuit pursuant to the

provisions of Rule 10(a) because the Sixth Circuit has decided an important federal question and has so far departed from the accepted and usual course of judicial proceedings or has sanctioned such a departure by a lower court as to call for an exercise of this court's supervisory power. This petition for writ of certiorari is likewise taken pursuant to the provisions of 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

One statutory provision involved in this case is 28 U.S.C. § 1332 which provides, in relevant part, as follows:

> (a) The district courts shall have original jurisdiction of all civil actions where the matter in controversy exceeds the sum or value of $75,000.00, exclusive of interest and costs, and is between –
>
> (1) Citizens of different states;
>
> (2) Citizens of a state and citizens or subjects of a foreign state;
>
> (3) Citizens of different states and in which citizens or subjects of a foreign state are additional parties; and
>
> (4) A foreign state, defined in section 1603(a) of this title, as plaintiff and citizens of a state or a different state.

> For the purposes of this section, section 1335, and 1441 an alien admitted to the United States shall be deemed a citizen of the state in which such alien is domiciled.

Also involved is 28 U.S.C. § 1441 which provides, in relevant part:

> (a) except as otherwise expressly provided by Act of Congress, any civil action brought in a state court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or defendants to the district court of the United States for the district and division embracing the place where such action is pending. For purposes of removal under this chapter, the citizenship of defendants sued under fictitious names shall be disregarded.
>
> (b) Any civil action of which the district courts have original jurisdiction founded on a claim or right arising out of the constitution, treaties or laws of the United States shall be removable without regard to the citizenship or residents of the parties. Any other such action shall be removable only if none of the parties in interest properly joined and served as defendants is a citizen of the state in which such action is brought.
>
> (c) Whenever a separate and independent claim or cause of action within the jurisdiction conferred by section 1331 is joined with one or more otherwise non removable claims or causes

of action, the entire case may be removed and the district court may determine all issues therein, or, in its discretion may remand all matters in which state law predominates.

STATEMENT OF THE CASE

Petitioners, Peggy Welshans Williamson and Vanessa Welshans, commenced this action in the circuit court of Shelby County, Tennessee and sought judgment for "three times the amount of their actual damages (including pre-judgment interest), which are to be determined at trial, or alternatively, their actual damages (including pre-judgment interest) plus the 25% penalty provided by Tenn. Code. Ann. § 56-7-105, but limited to $74,999.00 exclusive of interest, costs and attorneys fees." (Appendix 99a-100a) Respondent, Aetna Life Insurance Company ("Aetna"), then removed the action to the United States District Court for the Western District of Tennessee, Western Division predicated on diversity of citizenship under 28 U.S.C. § 1332. (Appendix 56a-65a) Ms. Williamson and Ms. Welshans filed a motion to remand the action to the Circuit Court of Shelby County, Tennessee. That motion was denied by the district court by an order entered on September 22, 2005. Ultimately the district court granted Aetna's motion for summary judgment by an order entered on November 17, 2005. (Appendix 28a-55a) A judgment in conformity with that order was entered and filed on November 21, 2005. (Appendix 24a-25a) From that judgment Williamson and Welshans filed their notice of appeal to the United States Court of Appeals for the Sixth Circuit on December 7, 2005.

Ms. Williamson and Ms. Welshans prosecuted their appeal to the Sixth Circuit in a timely manner. The first question addressed by the Sixth Circuit Court of Appeals was whether the district court possessed subject matter jurisdiction under 28 U.S.C. § 1332(a) and 28 U.S.C. § 1441(a). (Appendix 11a-17a) The Sixth Circuit Court of Appeals ultimately determined in their decision decided and filed on March 22, 2007 that "'it was more likely than not' that the 'potential cost of the state claim to the insurance company' *Woodmen*, 129 F. App'x. at 196, would exceed $75,000 and, thus, the district court correctly concluded that it possessed subject matter jurisdiction based on diversity of citizenship." (Appendix 17a) The court of appeals also affirmed the district court's summary judgment entered in favor of Aetna. That summary judgment ruling does not form the basis for an appeal to this court or this petition for writ of certiorari.

This is a review of a judgment of the United States Court of Appeal for the Sixth Circuit, and the only basis for federal jurisdiction in the court of first instance, the United States District Court for the Western District of Tennessee, was 28 U.S.C. § 1332. Petitioners suggest that there was, in fact, no such subject matter jurisdiction because the amount in controversy was specifically limited by their prayer for relief to less than the required jurisdictional amount.

ARGUMENT

On September 15, 2004, plaintiffs filed a complaint in Tennessee state court setting damages at less than $75,000. (Appendix 99a-100a) Aetna removed the action to federal district court based upon diversity of

citizenship in October 2004. (Appendix 56a-65a) Plaintiffs filed a motion to remand and argued that the amount in controversy did not satisfy federal requirements for jurisdiction based upon diversity of citizenship. The district court rejected this argument. The court of appeals wrote:

> The first question we must address is whether the district court possessed subject matter jurisdiction. Plaintiffs concede that the parties are diverse, but argue that the district court's denial of their motion to remand to state court was in error because the amended complaint alleged damages of less than $75,000, thereby falling short of the amount in controversy threshold for diversity jurisdiction. Aetna contends that diversity jurisdiction is established because it is "more likely than not" that plaintiffs' complaint seeks damages in excess of $75,000.

The allegations of the complaint, according to the court of appeals, were:

> In the second complaint, plaintiffs reassert the previously dismissed claims and request judgment three times the amount their actual damages ($74,999) (including prejudgment interest), which are to be determined at trial, or alternatively, their actual damages (including prejudgment interest) plus the 25 percent penalty provided by Tenn. Code Ann. 56-7-105, but limited to $74,999 exclusive of interest, costs, and attorneys fees.

The court of appeals acknowledged that under the general rule legal fees are excludable in determining the amount in controversy for purposes of federal diversity jurisdiction, unless the fees are provided for by contract or where a statute mandates or expressly allows the payment of such fees. *See Clark v. Nat. Travelers Life Ins. Co.*, 518 F.2d 1167, 1168 (6th Cir. 1975). The Sixth Circuit held, though:

> Here, two of the statutes upon which Williamson relies clearly allow the awarding of attorneys' fees. *See* Tenn. Code Ann. §§ 47-18-109(e)(1), 56-7-105.
>
> * * *
>
> Accordingly, we hold "it was more likely than not" that the "potential cost of the state claim to the insurance company," *Woodmen*, 129 F. App'x at 196, would exceed $75,000, and, thus, the district court correctly concluded that it possessed subject matter jurisdiction based on diversity of citizenship.

(Appendix 17a)

In their original complaint, Ms. Welshans and Ms. Williamson specifically pleaded that they were seeking a total judgment "limited to $74,999," the summonses that were issued and served upon Atena specifically stated that the damages sought are less than $75,000, and the total amount of the denied claims was specifically listed and attached as an exhibit to the complaint totaling only about $28,000. See Complaint and Amended Complaint. (Appendix 66a-101a) They

pleaded each claim in the alternative and never claimed to recover under each theory cumulatively, because the damages all resulted from Atena's refusal to pay Ms. Welshans' claims. Each sought less than $75,000. The prayer clause in the amended complaint, which encompasses all of their claims, specifically requests a judgment (under the claims collectively) for only $74,999. (Appendix 99a-100a)

They never contended that they were entitled to recover an amount in excess of the minimum amount required for federal diversity jurisdiction and, to the extent that there is a question of the extent of damages (given the numerous claims and varying amounts) caused by Aetna's refusal to pay Ms. Welshans' medical claims, they specifically stated in the prayer clause of their amended complaint and in the summonses that the judgment sought was less than $75,000. This is not a case of plaintiffs trying to stipulate only after the case was removed – Ms. Williamson and Ms. Welshans specifically pleaded and sought less than the jurisdictional amount required for federal diversity jurisdiction.

Because federal courts are courts of limited jurisdiction, 28 U.S.C. § 1441 is strictly construed against removal, and a "plaintiff is the master of his or her own claim; if the plaintiff chooses to ask for less than the jurisdictional amount, only the sum actually demanded is in controversy," Wright & Miller, 14A Federal Practice & Procedure § 3702. A plaintiff's choice of forum and a defendant's right of removal are not on the same footing. *Burns v. Windsor Ins. Co.*, 31 F.3d 1092 (11th Cir. 1994).

Because federal courts are courts of limited jurisdiction even though a defendant does have a right, given by statute, to remove in certain situations, a plaintiff is still the master of his own claim. *Caterpillar, Inc. v. Williams*, 482 U.S. 386, 391 & n. 7, 107 S.Ct. 2425, 2429 & n.7, 96 L.Ed.2d 318 (1987); *Great Northern R. Co. v. Alexander*, 246 U.S. 276, 282, 38 S.Ct. 237, 239, 62 L.Ed. 719 (1918); *Gafford v. General Electric*, 997 F.2d 150 (6th Cir. 1993); *see also Insigna v. LaBella*, 845 F.2d 249, 253-54 (11th Cir. 1988); *Lane v. Champion Int'l Corp.*, 844 F.Supp. 724, 731 (S.D. Ala. 1994); *see generally* Wright & Miller, 14A Federal Practice and Procedure § 3702 ("plaintiff is the master of his or her own claim; if plaintiff chooses to ask for less than the jurisdictional amount, only the sum actually demanded is in controversy"); *St. Paul Mercury Indem. Co. v. Red Cab Co.*, 303 U.S. 283, 58 S. Ct. 586 (1938).

Because a defendant's right to remove the pending claim to federal court and a plaintiff's right to choose his forum are not on equal footing removal statutes are construed narrowly. Where a plaintiff and defendant clash about jurisdiction, uncertainties are to be resolved in favor of remand. *Bover v. Snap-on Tools Corp.*, 913 F.2d 108 (3rd Cir. 1990), *cert. denied*, 498 U.S. 1085, 111 S.Ct. 959, 112 L.Ed.2d 1046 (1991).

In the absence of any demand by Ms. Williamson and Ms. Welshans in their complaints for an award of damages in excess of $75,000 (and, to the contrary, the presence of a specific request for an award of less than $75,000.00), Aetna failed to demonstrate that it was more likely than not that the amount in controversy would be more than $75,000 – especially in light of

petitioners' actual damages which totaled only $28,115.13. To the extent that it is necessary to reiterate what petitioners specifically requested in their state court complaints, they stipulated (and still do) that they do not and will not seek or request judgment in the amount of $75,000 or greater, exclusive of interest and costs.

Federal jurisdiction is never presumed. *Viquiera v. First Bank*, 140 F.3d 12, 16 (1st Cir. 1998). "The party invoking the jurisdiction of a federal court carries the burden of proving its existence." *Murphy v. United States*, 45 F.3d 520, 522 (1st Cir.), *cert.denied*, 515 U.S. 1144 (1995) (quoting *Taber Partners, I v. Merit Builders, Inc.*, 987 F.2d 57, 60 (1st Cir.), *cert.denied*, 510 U.S. 823 (1993)).

The total unpaid claims alleged by petitioners barely exceed $28,000. Even including legal fees, the breach of contract claim and statutory bad faith claims (even with a statutory penalty of 25%) the total judgment could not possibly reach the $75,000 threshold. The only claim which arguably approaches the $75,000 threshold amount was their Consumer Protection Act claim, which would permit them to recover attorneys' fees (which are discretionary), but, again, petitioners specifically limited their prayer to less than $75,000.

Significantly Aetna provided no evidence to establish federal diversity jurisdiction as to *each* of these petitioners. In order to have federal diversity jurisdiction for each of the petitioners, Aetna had to show that it was more likely than not that each claimed an amount in excess of the minimum

jurisdictional amount of $75,000. This Aetna failed to do.

Removal impinges upon state sovereignty and implicates significant federalism principles, and 28 U.S.C. § 1441 must be narrowly and strictly construed. *Shamrock Oil & Gas Corp. v. Sheets*, 313 U.S. 100 (1941).

Although the general rule is that legal fees are excusable in calculating the amount in controversy because the successful party does not collect her legal fees in addition to or as part of the judgment, where an underlying statute authorizes an award of legal fees, either with mandatory or discretionary language, such fees may be included in the amount in controversy. *Galt G/S v. JSS Scandinavia* 142 F.3d 1150 (9th Cir. 1998).

In a dispute that centered on the effect of anti-stacking clauses in two uninsured motorists policies plaintiff sought benefits under a policy that had a $100,000 liability limit. He conceded that he could receive, at most, $50,000 from that policy because under Neb. Rev. Stat. § 30-2722(b), it was presumed that plaintiff and his wife were entitled to equal shares of $100,000 in benefits that had already been paid. As a result his claim did not satisfy the amount in controversy requirement for diversity jurisdiction under 28 U.S.C. § 1332, and plaintiff could not include attorneys fees in his damages calculation because only statutory fees could be counted to meet the amount in controversy requirement. *Rasmussen v. State Farm Mut. Auto Ins. Co.*, 410 F.3d 1029 (8th Cir. 2005).

Attorneys fees generally do not constitute part of the "amount in controversy" for purposes of determining jurisdiction; however, reasonable attorney's fees can be included in the assessment of amount in controversy when provided by statute. *Spielman v. Genzyme Corp.*, 193 FRD 19, *aff'd* 251 F.3d 1 (1st Cir. 2001).

If a state statute provides that attorney's fees may be recovered if an insurance company's refusal to settle a claim is vexatious and without reasonable cause, a claim for attorney's fees can be included as part of the jurisdictional amount under 28 USCS § 1332 so long as pleadings do not show to a legal certainty that the amount claimed cannot be established. *Velvez v. Crown Life Ins. Co.*, 599 F.2d 471 (1st Cir. 1979).

A reasonable estimate of legal fees may be included in determining whether the jurisdictional minimum is satisfied where a party has a right, based upon contract, statute, or other legal authority to an award of legal fees if such party prevails in the litigation. *Ross v. Inter-Ocean Ins. Co.*, 693 F.2d 659 (7th Cir. 1982).

But, each plaintiff's share of legal fees recoverable cannot be aggregated to satisfy the amount in controversy requirement since each plaintiff had a separate and distinct statutory right or claim to recover those legal fees. *Darden v. Ford Consumer Fin. Co.*, 200 F.3d 753 (11th Cir. 2000), *reh'g en banc denied*, 211 F.3d 596.

This court long ago announced that only when suit is brought to restrain the imposition of a penalty already accrued by reason of failure to comply with a statute or order assailed can the penalty be included as part of the matter in controversy. *Healy v. Ratta*, 292 U.S. 263, 54 S.Ct. 700, 78 L.Ed. 1248 (1934). Ordinarily penalties which merely might be incurred or the amount of which is uncertain may not be included in determining the amount in controversy. *Henneford v. Northern P. R. Co.*, 303 U.S. 17, 58 S.Ct. 415, 82 L.Ed. 619 (1938).

In *Martin v. Franklin Capital Corporation*, 251 F.3d 1284 (10th Cir. 2001), that appellate court said, "the courts must rigorously enforce Congress' intent to restrict federal jurisdiction in controversies between citizens of different states." *See also Miera v. Dairyland Ins. Co.*, 143 F.3d 1337, 1339 (10th Cir. 1998). The presumption is therefore "against removal jurisdiction," *Laughlin v. Kmart Corp.* 50 F.3d 871, 873 (10th Cir. 1995).

In a removed case, unlike a case instituted in federal court, the plaintiff chose a state rather than federal forum. Because the plaintiff instituted the case in state court, "there is a strong presumption that the plaintiff has not claimed a large amount in order to confer jurisdiction on a federal court or that the parties have colluded to that end." *Martin v. Franklin Capital Corporation, supra.*

Under *McNutt v. General Motors Acceptance Corp.*, 298 U.S. 178, 189, 56 S.Ct. 780, 80 L.Ed. 1135 (1936), the party asserting jurisdiction must prove jurisdictional prerequisites by a preponderance of the

evidence. According to a decision from the Tenth Circuit, this court has historically interpreted Section 1332 "to require plaintiffs who have separate and distinct claims, but united together in a single suit, to **each** meet the jurisdictional amount in controversy." *Leonhardt v. Western Sugar Co.*, 160 F.3d 631, 637 (10th Cir. 1998) (emphasis supplied).

Simply put, the claims of each petitioner were specifically limited by their pleadings to less than $75,000. Aetna has offered no evidence that this amount, as to each petitioner, would exceed the minimum jurisdictional amount required for federal diversity jurisdiction, and as a result remand to the state court should have been granted.

CONCLUSION

Ms. Welshans and Ms. Williamson chose to file a lawsuit in state court and specifically limited their collective prayer for relief to an amount less than the jurisdictional amount required by federal statute to authorize diversity of citizenship jurisdiction. Despite that clear limitation the federal district court elected to take jurisdiction over the case and refused to remand the matter to State court where it belonged. The Sixth Circuit Court of Appeal affirmed the District Court's action. Petitioners, Ms. Welshans and Ms. Williamson, suggest both the District Court and the Court of Appeals departed from established precedent established by this court and by other courts of appeal throughout the nation by allowing Aetna to aggregate the claims of both petitioners and by ignoring the limited prayer for relief set forth in the state court pleadings and by exercising jurisdiction when Aetna

came forward with none of the required proof that the amount at risk actually exceeded $75,000, exclusive of interest and costs as to each of the petitioners. Petitioners respectfully request that this court grant certiorari so that this court can resolve the parameters of diversity jurisdiction.

Respectfully submitted,

PEGGY WELSHANS WILLIAMSON
and VANESSA WELSHANS

By: Kathleen G. Morris
P.O. Box 128091
42 Rutledge Street
Nashville, TN 37210
(615) 320-8899

AND

Lawrence W. Jackson
Counsel of Record
Rieves, Rubens & Mayton
P.O. Box 1359
304 East Broadway
West Memphis, AR 72303
(870) 735-3420

Attorneys for Petitioners

APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 05-6911

[Filed July 12, 2007]

PEGGY WELSHANS WILLIAMSON, ET AL., Plaintiffs-Appellants,

v.

AETNA LIFE INSURANCE COMPANY, Defendant-Appellee.

JUDGES: BEFORE: SILER, GILMAN, and GRIFFIN, Circuit Judges.

OPINION

ORDER

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

/s/
Leonard Green, Clerk

APPENDIX B

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 05-6911

[Filed March 22, 2007]

PEGGY WELSHANS WILLIAMSON,
and
VANESSA WELSHANS,
Plaintiffs-Appellants,
v.
AETNA LIFE INSURANCE COMPANY,
Defendant-Appellee.

Appeal from the United States District Court for the Western District of Tennessee at Memphis.
No. 04-02851 - J. Daniel Breen, District Judge

JUDGES: Before: SILER, GILMAN, and GRIFFIN, Circuit Judges.

OPINION

GRIFFIN, Circuit Judge. Plaintiffs Peggy Welshans Williamson and Vanessa Welshans appeal the district court's grant of summary judgment in favor of defendant Aetna Life Insurance Company ("Aetna"). Plaintiffs initially brought suit in Tennessee state court alleging violations of common law breach of contract, violations of the Tennessee Consumer Protection Act ("TCPA"), TENN. CODE ANN. § 47-18-104, and the Tennessee "bad faith" statute, TENN. CODE ANN. § 56-7-105. Specifically, plaintiffs alleged that Aetna wrongfully denied health insurance benefits for Williamson's daughter, Welshans, pursuant to an employee health plan administered by Aetna. In October 2004, Aetna removed the matter to federal district court, and, in November 2005, the district court granted Aetna's summary judgment motion with respect to all of plaintiffs' claims. Plaintiffs now urge this court to reverse both the jurisdictional determination of the district court and its subsequent grant of summary judgment in favor of Aetna.

For the reasons that follow, we affirm.

I.

Williamson was employed by General Agencies of the United Methodist Church ("General Agencies") from 1977 until she retired in 1995. General Agencies provided group health insurance (the "plan") to its employees, and, as part of Williamson's retirement, she continued to be eligible for the plan. Williamson was a member of the task force at General Agencies

that designed the employer's insurance plan and recommended that Aetna be selected as the plan administrator. Based on that recommendation, General Agencies contracted with Aetna to administer its group health plan from January 1, 1990, through December 31, 2000.

Welshans is Williamson's daughter. In May 1983, when Welshans was twenty-two years old, she was severely injured in an automobile accident in which she sustained broken legs, a broken pelvis, and a broken back. According to plaintiffs, her left knee was severely injured as a result of the accident, and she has subsequently undergone seven surgeries. Her ability to sit, stand, walk, climb stairs, or do any bending or squatting for a sustained period of time is impaired. Until 1986, when Welshans reached the maximum age for coverage as a dependent child, she was eligible for coverage under Williamson's plan through General Agencies. After 1986, Welshans was provided continued coverage by Cigna, the prior administrator of General Agencies' health plan, as a "fully handicapped dependent" because of the injuries she sustained in the accident. Welshans received coverage as a "handicapped dependent" from 1986 to 1995 pursuant to the terms of the plan with Cigna.

Welshans has not been employed since the accident, but she has been a full-time student since 1994. In 1994, she attended East Arkansas Community College in Wynne, Arkansas. In 1995, she transferred to Lambuth University in Jackson, Tennessee. Following her graduation from Lambuth, she earned a masters degree in American history from the University of Memphis in 2000 and has since

enrolled in the doctoral program. At the time of her deposition, she expected to complete a doctorate in American History and Modern Europe in 2004. According to Aetna's brief, she has since completed the doctorate. Welshans is physically and mentally able to care for herself, and she lived independently in Wynne, Arkansas, while attending community college. She occasionally lived with her mother while attending Lambuth University from 1995-1998, and, since 1998, has lived alone in the Memphis and Collierville, Tennessee area. Welshans has received Social Security Disability income since 1984 and has no other source of disposable income. Welshans transfers money from Williamson's bank account into her own account each month as needed to meet her living expenses, including rent, bills, and food.

Welshans and Williamson both participated in the indemnity provisions of General Agencies' group health plan during the time in which Aetna served as the administrator. The indemnity provisions provided that the insured was responsible for the submission of claims to Aetna. The plan further identified procedures and other health care services that were excluded from the plan.

In January 1995, when Aetna began administering the plan, Welshans was thirty-four years of age. Because of her age, Welshans was ineligible for coverage as a dependent child of Williamson. The plan provided, however, that "Health Insurance Coverage for [the insured's] fully handicapped dependent may be continued past the maximum age for a dependent child, if he or she has not been issued a personal

medical conversion policy." The plan defined a "fully handicapped dependent" as a person:

> not able to earn his or her own living because of mental retardation or physical handicap which started prior to the date he or she reaches the maximum age for dependents; and
>
> he or she chiefly depends on [the insured] or another care provider for support.

"Dependent on another care provider" is defined as requiring a "Community Integrated Living Arrangement, group home supervised apartment or other residential services licensed or certified by the Department of Mental Health and Developmental Disabilities, the Department of Public Health or the Department of Public Aid."

According to the plan, once coverage has been established, it will continue until any one of the following occurrences: (1) "cessation of the handicap and dependency"; (2) "[t]he end of a 60 day period from the date Aetna requests proof of the continuation of the handicap and dependency, if proof is not provided within a 60 day period"; or (3) "Termination of Dependent Coverage as to [the insured's] dependent for any reason other than reaching the maximum age." The plan specifically confers upon Aetna the right to "request proof of the continuation of the handicap as often as it may reasonably require, but not before 2 months prior to the dependent reaching the maximum age."

When Aetna took over the administration of the General Agencies health plan in 1995, it initially rejected medical claims submitted by Welshans and other children of insured employees, whom Cigna had previously provided coverage for as handicapped dependents, because of a computer error. In response to the error, Aetna instituted a policy by which it would "cover all incapacitated dependents [including Welshans] without question" for the calendar year 1995. Aetna further stated that it expected to return to normal procedures to determine eligibility by January 1, 1996, at which time dependents could be terminated if they did not meet the plan's eligibility criteria.

On July 26, 1996, Aetna first denied Welshans' coverage as a handicapped dependent. According to Williamson and Aetna's internal notes, Aetna determined that she was "not handicapped as described in the plan because the physical limitations described do not seem to be of a severity to preclude full time employment." Williamson sent a second request for continuation of coverage in August 1996, along with a statement from Welshans' doctor, Dr. Thomas Limbird, describing her injuries in detail and opining that she was unable to maintain employment. Aetna requested additional information regarding Welshans' dependent and marital status in a letter dated September 14, 1996.

It is unclear whether further determinations were made as to Welshans' eligibility in 1996, 1997, or 1998. Some form of litigation between the two parties has been ongoing since 1996. Welshans originally filed suit against Aetna in federal district court in 1996, alleging diversity jurisdiction and seeking payment of medical

benefit claims. This matter was resolved by settlement in June 1998, and Aetna states that "it is undisputed that Aetna extended coverage to Welshans as a handicapped dependent from 1995-1999."[1]

On October 8, 1999, and November 8, 1999, Aetna again requested verification of Welshans' status as a handicapped dependent. It is unclear whether plaintiffs responded to these requests. Aetna claims that plaintiffs did not respond, citing both the deposition testimony of Aetna's employee and internal notes recording the non-receipt of this requested information. Williamson did not produce any documentary evidence or recall a specific date, but generally alleged that she responded to all requests for information.

Although the district court states that "It [was] undisputed that Aetna terminated Welshans' coverage in 1999," the termination date is unclear from the record. It is clear that Aetna denied many of Welshans' claims in 1999. Aetna's internal notes, dated November 16, 1999, state that "no incapacitated child info received[;] will close out the contact." Further, Aetna's list of claims states, for the first time, on February 26, 2000, that a claim was denied because coverage was terminated. Around the same time, however, Aetna mailed Williamson a "Certification of

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[1] The parties appear to agree that this prior matter was resolved by settlement, but Aetna proffers that "[a]mong the settlement terms was the requirement that Welshans submit all necessary proof and other documentation required by the health plan to establish her coverage under the plan."

Prior Group Health Coverage," prepared on May 19, 2000, which provided "evidence of prior health coverage" for Welshans from January 1, 1995, to January 2, 2000. Neither the district court opinion nor Aetna addresses this document.

On January 22, 1999, plaintiffs filed separate complaints in district court[2] alleging diversity jurisdiction and stating claims for breach of contract and violations of the Tennessee Consumer Protection Act and the Tennessee "bad faith" statute as a result of Aetna's alleged failure to pay Welshans' medical claims. In September 2003, prior to the conclusion of a bench trial, plaintiffs voluntarily non-suited their case, and the court dismissed the action without prejudice. Subsequently, on September 15, 2004, plaintiffs filed a complaint in Tennessee state court setting damages at less than $ 75,000. Aetna removed the action to federal district court based on diversity of citizenship in October 2004. Plaintiffs filed a motion to remand, arguing that the amount in controversy did not satisfy federal requirements. The district court rejected this argument, and subsequently granted Aetna's summary judgment motion on the merits of the case, concluding that plaintiffs had failed to set forth any evidence that a breach of contract occurred, or that Aetna acted deceitfully or in bad faith. Plaintiffs timely appealed.

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[2] Plaintiffs' separate complaints were thereafter consolidated by the state court in March 2000.

II.

The district court denied plaintiffs' motion to remand and granted Aetna's summary judgment motion; thus, the standard of review is de novo. *Davis v. McCourt*, 226 F.3d 506, 509 (6th Cir. 2002); *Terry Barr Sales Agency, Inc. v. All-Lock Co.*, 96 F.3d 174, 178 (6th Cir. 1996).

The first question we must address is whether the district court possessed subject matter jurisdiction. Plaintiffs concede that the parties are diverse, but argue that the district court's denial of their motion to remand to state court was in error because the amended complaint alleged damages of less than $75,000, thereby falling short of the amount-in-controversy threshold for diversity jurisdiction. Aetna contends that diversity jurisdiction is established because it is "more likely than not" that plaintiffs' complaint seeks damages in excess of $75,000.

Removal of cases from state to federal court is governed by 28 U.S.C. § 1441(a), which provides that "any civil action brought in state court of which the district courts of the United States have original jurisdiction may be removed by the defendant or the defendants to the district court of the United States . . . where such action is pending." 28 U.S.C. § 1441(a). Federal district courts have original jurisdiction over "all civil actions where the matter in controversy exceeds the sum or value of $75,000, exclusive of interest and costs, and is between . . . citizens of different states." 28 U.S.C. § 1332(a). A defendant seeking to remove a case to federal court has the burden of proving that the district court possesses

jurisdiction. *Gafford v. Gen. Elec. Co.*, 997 F.2d 150, 155 (6th Cir. 1993). Jurisdiction is determined at the time of removal, and subsequent events, "whether beyond the plaintiff's control or the result of his volition, do not oust the district court's jurisdiction once it has attached." *St. Paul Mercury Indem. Co. v. Red Cab Co.*, 303 U.S. 283 (1938); *Rogers v. Wal-Mart Stores, Inc.*, 230 F.3d 868, 872 (6th Cir. 2000).

On September 15, 2004, plaintiffs filed their second amended complaint[3] in the Circuit Court of Shelby County, Tennessee, which was amended on September 20, 2004. In the second complaint, plaintiffs reassert the previously dismissed claims and request

> judgment three times the amount of their actual damages [$74,999] (including pre-judgment interest), which are to be determined at trial, or alternatively, their actual damages (including pre-judgment interest) plus the 25 percent penalty provided by Tenn. Code Ann. § 56-7-105, but limited to $74,999 exclusive of interest, costs, and attorneys fees.

Plaintiffs aver that this limitation means that Aetna cannot demonstrate that the amount in controversy exceeds $ 75,000.

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[3] Plaintiffs' first complaint in federal court sought actual damages "in an amount as yet undetermined but in excess of $75,000." As stated, in September 2003, plaintiffs voluntarily non-suited their case, and the district court dismissed the action without prejudice.

The district court held that, although generally plaintiffs "may choose to claim less than the federal requirement in order to preclude removal from state court," Tennessee's rules of civil procedure enabled plaintiffs to claim an amount lower than the jurisdictional amount in the complaint, yet seek to recover damages in excess of that amount (citing TENN. R. CIV. P. 54.03). Tennessee Rule 54.03 provides that "every final judgment shall grant the relief to which the party in whose favor it is rendered is entitled, even if the party has not demanded such relief in the party's pleadings." TENN. R. CIV. P. 54.03. Thus, the district court concluded, Aetna must demonstrate that it was "more likely than not" that the amount in controversy would exceed $75,000. *See Rogers*, 230 F.3d at 871 (6th Cir. 2000).

To this effect, the district court continued:

> The amount in controversy is determined by the allegations in the complaint. *National Nail Corp. v. Moore*, 139 F. Supp. 2d 848, 850 (W.D. Mich. 2001) (citing *Laughlin v. KMart Corp.*, 50 F.3d 871, 873 (10th Cir. 1995)). In their complaint, Plaintiffs allege that, as a result of Defendants wrongful acts in denying Welshans medical insurance claims during the period of 1995-2000, they have suffered damages in the amount of $74,999. . . . Plaintiffs further aver that they are entitled to recover treble the amount of actual damages pursuant to Tenn. Code Ann. § 47-18-109 and an additional twenty-five percent penalty on all sums recovered under Tenn. Code Ann. § 56-7-105 . . . . Calculating the relief requested using the

damages suffered, the complaint asserts that Plaintiffs are entitled to recover up to $74,999 under Count I; $223,997 under Count II; and $93,748.75 under Count III.

On appeal, plaintiffs attempt to reargue the same objections they made before the district court; namely, that the stipulation in their Motion to Remand that "they do not and will not seek or request judgment in the amount of $75,000 or greater, exclusive of interest and costs," precludes federal jurisdiction. We need not reach this argument because we hold that the request for attorneys' fees properly placed this case within the purview of federal jurisdiction, and we thereby affirm the district court's exercise of jurisdiction on other grounds. *City Mgmt. Corp. v. U.S. Chem. Co., Inc.*, 43 F.3d 244, 251 (6th Cir. 1994) ("[W]e may affirm on any grounds supported by the record, even though they may be different from the grounds relied on by the district court." (citing *Hilliard v. U.S. Postal Service*, 814 F.2d 325, 326 (6th Cir. 1987)).

As a general rule, attorneys' fees are excludable in determining the amount in controversy for purposes of diversity, unless the fees are provided for by contract or where a statute mandates or expressly allows the payment of such fees. *Clark v. Nat. Travelers Life Ins. Co.*, 518 F.2d 1167, 1168 (6th Cir. 1975) ("It is settled that the statutory penalty and a statutory attorney's fee can be considered in determining whether the jurisdictional amount is met.").

We have recently applied this principle, albeit in an unpublished opinion.[4] In *Woodmen of the World / Omaha Woodmen Life Ins. Soc'y v. Scarbro*, 129 F. App'x 194, 195-96 (6th Cir. 2005) (unpublished), we examined what constituted "costs" in a plaintiff's claim for declaratory judgment. The plaintiff, Woodmen, appealed a district court's order granting summary judgment to the defendant in an action filed by the insurance company seeking to force Scarbro to arbitrate a dispute under an insurance contract previously entered between the parties. The district court found that the amount in controversy was insufficient to establish subject matter jurisdiction in federal court and entered an order of dismissal. We reversed, stating:

> It is generally agreed in this circuit that the amount in controversy should be determined "from the perspective of the plaintiff, with a focus on the economic value of the rights he seeks to protect." *Buckeye Recyclers v. CHEP USA*, 228 F. Supp. 2d 818, 821 (S.D. Ohio 2002); *see Pennsylvania R. Co. v. City of Girard*, 210 F.2d 437 (6th Cir. 1954); *Goldsmith v. Sutherland*, 426 F.2d 1395, 1398 (6th Cir. 1970); Wright, Miller & Cooper, Federal Practice and Procedure: Jurisdiction § 3708 (3d ed. 1998).

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[4] Unpublished opinions of this court are not precedentially binding under the doctrine of stare decisis. *United States v. Sanford*, 476 F.3d 391, 2007 WL 325742, at *4 (6th Cir. Feb. 6, 2007).

Woodmen, 129 F. App'x at 195-96. This amount, we concluded, included not only the face value of the insurance contract, but also compensation awardable by law for mental anguish and for loss of business income, attorneys' fees, and punitive damages. *Id.* In short, "the 'object' of th[e] litigation, cannot be determined without reference to the potential cost of the state claim to the insurance company." *Id.* at 196.

Although the *Woodmen* case is neither factually identical to this case, nor precedentially binding, we have affirmed the general principle of considering statutorily authorized attorneys' fees for purposes of establishing jurisdiction, *Clark*, 518 F.2d at 1168-69, and determine that it is likewise appropriate in this case. *See also Stokes v. Reeves*, 245 F.2d 700 (9th Cir. 1957) (holding that where there is a state statute allowing attorneys' fees, it is applicable in diversity cases, and the amount claimed thereunder may be taken into account in determining whether the jurisdictional amount is involved); *Johnson v. America Online, Inc* ., 280 F. Supp. 2d 1018 (N.D. Cal. 2003) (holding that, typically, attorneys' fees are not considered part of amount in controversy for diversity purposes; however, where underlying statute authorizes award of attorney fees, those fees may be included in calculating amount in controversy); *In re High Fructose Corn Syrup Antitrust Litig.*, 936 F. Supp. 530 (C.D. Ill. 1996) (holding that attorneys' fees can be considered in determining whether plaintiff has satisfied amount-in-controversy requirement for diversity jurisdiction, where statute mandates or allows payment of such fees, although as general rule attorneys' fees are excluded in determining amount in controversy); *Hendrickson v. Xerox Corp.*, 751 F. Supp.

175 (D. Or. 1990) (holding that for purposes of determining if amount in controversy satisfies jurisdictional requirements, attorneys' fees may be taken into account if statute authorizes awarding fees to successful litigant); *Hall v. Travelers Ins. Co.*, 691 F. Supp. 1406 (N.D. Ga. 1988) (holding that where attorneys' fees are allowable by applicable law, they may be included in assessing jurisdictional amount in controversy for purposes of diversity jurisdiction).

Here, two of the statutes upon which Williamson relies clearly allow the awarding of attorneys' fees. *See* TENN. CODE ANN. §§ 47-18-109(e)(1), 56-7-105. Further, as the district court recounted, the plaintiffs second complaint requested:

> judgment three times the amount of their actual damages [$74,999] (including pre-judgment interest), which are to be determined at trial, or alternatively, their actual damages (including pre-judgment interest) plus the 25 percent penalty provided by Tenn. Code Ann. § 56-7-105, but limited to $74,999 exclusive of interest, costs, and attorneys fees.

Accordingly, we hold "it was more likely than not" that the "potential cost of the state claim to the insurance company," *Woodmen*, 129 F. App'x at 196, would exceed $75,000, and, thus, the district court correctly concluded that it possessed subject matter jurisdiction based on diversity of citizenship.

III.

Next, plaintiffs contend that the district court erred in holding that there were no genuine issues of material fact with respect to their asserted claims and, accordingly, urge this court to reverse. The thrust of plaintiffs' argument, however, remains the same. Instead of addressing the grounds on which the district court held that Aetna permissibly terminated Welshans' coverage -- that she did not reply to Aetna's request for more information -- plaintiffs argue that Aetna had all of the information it needed on file and, accordingly, was wrong in denying Welshans' claims. We disagree.

A. *Tennessee Consumers' Protection Act.*

The district court correctly noted that to establish a claim pursuant to the Tennessee Consumers' Protection Act ("TCPA"), a plaintiff must prove "(1) that the defendant engaged in an unfair or deceptive act or practice declared unlawful by the TCPA; and (2) that the defendant's conduct caused an 'ascertainable loss of money or property, real, personal, or mixed, or any other article, commodity, or thing of value wherever situated . . . .'" (citing *Tucker v. Sierra Builders*, 180 S.W.3d 109, 115-16 (Tenn. Ct. App.), *app. denied* (Tenn. 2005) (quoting TENN. CODE ANN. § 47-18-109(a)(1))). In a well-reasoned discussion, the district court examined plaintiffs' arguments and concluded that they had not alleged these elements with any specificity, excepting Welshans' eligibility as a handicapped dependent. With respect to this allegation, the district court concluded that, at worst, these denials amounted to an "erroneous denial" of a

claim and, accordingly, did not constitute an act of deception or unfairness (citing *Hamer v. Harris*, 2002 WL 31469213, *1 (Tenn. Ct. App. Nov. 6, 2002)). We see no reason to disturb this holding or analysis.

B. *Bad Faith Claims.*

Plaintiffs further contend that the district court erred in concluding that they had submitted insufficient evidence to substantiate their claims of bad faith. Plaintiffs allege that Aetna "knowingly disregarded the evidence in its file and the language of the Plan" that Welshans was a handicapped dependent and, further, "took affirmative steps to secretly alter the Plan terms for handicapped dependent without ever actually modifying the Plan or advising Appellants and other insureds."

The district court correctly set forth the elements of a bad faith claim pursuant to Tennessee law. *See* TENN. CODE ANN. § 56-7-105. In the context of a claim for bad-faith denial of insurance coverage, a plaintiff must demonstrate: "(1) that the insurance policy, by its terms, became due and payable; (2) that a formal demand for payment was made; (3) that Plaintiffs waited sixty days after making demand before filing suit; and (4) that Aetna's refusal to pay was not in good faith." (citing *Palmer v. Nationwide Mut. Fire Ins. Co.*, 723 S.W.2d 124, 126 (Tenn. Ct. App. 1986). Plaintiffs, the insured, bear the burden of proving bad faith on the part of Aetna in denying payment. *See id.* "A penalty is not appropriate when the insurer's refusal to pay rests on legitimate and substantial legal grounds." *Tyber v. Great Central Ins. Co.*, 572 F.2d 562, 564 (6th Cir. 1978).

As Aetna notes, plaintiffs' attempt to shift the burden of proof, thereby requiring Aetna to prove that it acted in good faith, is without merit. Plaintiffs have simply not put forth any evidence which disproves Aetna's proffered reasons for denying Welshans' claims. In short, plaintiffs ask us to hold that Aetna's failure to accept the ten-year old, previously-submitted letter from her doctor rendered their denial of Welshans' claims erroneous and in bad faith. The record reflects, and the district court concluded, that all of Aetna's refusals to pay claims were based upon legitimate grounds for disputing the claims consistent with the terms of the plan. Plaintiffs have not put forth evidence to demonstrate otherwise. Plaintiffs' allegation that Aetna "took affirmative steps to secretly alter the Plan terms for handicapped dependent without ever actually modifying the Plan or advising Appellants and other insureds" is unsupported by the record. The document that plaintiffs direct us to is a summary of the plan benefits, not the language of the contract. The very next exhibit, presumably a portion of the same document, contains a disclaimer characterizing the document as a summary and cautions, "[i]f there is a difference between the information in this summary and the Plan documents, the Plan documents and contracts will govern." Thus, plaintiffs' unsupported allegation is without merit.

C. *Breach of Contract.*

Finally, plaintiffs contend that the district court erred in its ruling that there was insufficient evidence to demonstrate that Aetna breached the contract. Under Tennessee law, an insurance policy is to be

"given its plain and ordinary meaning." Security Ins. Co. v. Kevin Tucker & Assocs., *Inc.*, 64 F.3d 1001, 1006 (6th Cir. 1995). The court must read the policy according to its lay terms. *Davidson Hotel Co. v. St. Paul Fire & Marine Ins. Co.*, 136 F. Supp. 2d 901, 905 (W.D. Tenn. 2001). "Where there is an ambiguity or uncertainty with regards to the terms of an insurance policy, the court must interpret the terms strictly against the drafter of the policy." *NSA DBA Benefit Plan, Inc. v. Conn. Gen. Life Ins. Co.*, 968 S.W.2d 791, 795 (Tenn. Ct. App. 1997).

One of the problems in ascertaining the key dates in the life and termination of this contract is that Aetna paid some claims while simultaneously denying other claims. The district court divided the claims into two groups: (1) claims submitted between 1995 and 1998, some of which were paid, and some of which were denied for reasons -- Aetna proffers -- at least facially consistent with the plan; and (2) claims following Aetna's request, and plaintiffs' apparent failure to provide, for continued documentation of Welshans' handicapped dependent status.

With respect to claims submitted from 1995 to 1998, the district court held that plaintiffs had not submitted sufficient evidence for it to determine that a breach of contract took place, stating:

> [F]rom the information provided by Plaintiffs, the Court is unable to make any determination regarding the validity of Aetna's actions under the contract. Plaintiffs' list of claims provides only the date, provider name, amount claimed and response by Aetna. Because the Plaintiffs

> have not provided any information or argument to the Court regarding the basis for the claim and how Aetna's action departed from the terms of the Plan, the Court is unable to make any determination as to whether the claim for the service or product was wrongfully processed. Where Plaintiffs have not supplied an argument for breach of contract on any of the more than 180 claims listed, the Court will not endeavor to do it for them. See *Skotak v. Tenneco Resins, Inc.*, 953 F.2d 909, 916 n.7 (5th Cir. 1992) ("Rule 56 does not impose upon the district court a duty to sift through the record in search of evidence to support a party's opposition to summary judgment. . . . Rule 56 allocates that duty to the opponent of the motion, who is required to point out the evidence, albeit evidence that is already in the record, that creates an issue of fact.").

This conclusion is correct. Although Aetna decidedly paid some of Welshans' claims and denied others, plaintiffs put forth no evidence as to why the denial of the contested claims was inconsistent with the contract. Unfortunately, plaintiffs have proffered the same unsupported arguments on appeal.

Regarding the claims submitted after December 9, 1999, the district court held that Aetna could permissibly deny the claims. Specifically, it held:

> As noted above, the Plan provided Aetna with the authority to request proof of Welshans' continued handicap and dependency as it may "reasonably require" to make determinations

regarding her eligibility for coverage. . . . As the Court has already determined that Aetna's requests for such information in 1999 were reasonable in light of the circumstances, the only remaining issue is whether Aetna was within its contractual rights to terminate Welshan's [sic] coverage in 1999. The contract provides Aetna with authority to terminate at "[t]he end of a 60 day period from the date Aetna requests proof of the continuation of the handicap and dependency, if proof is not provided within the 60 day period." The uncontroverted evidence demonstrates that Aetna requested such proof on October 8, 1999. Defendant avers that Plaintiffs failed to respond to the request. Plaintiffs have not directed the Court to any evidence to demonstrate that this fact is in dispute. Accordingly, pursuant to the terms of the contract, Aetna could rightfully terminate Welshans' coverage on December 9, 1999.

We agree with the district court's analysis and adopt it as our own.

IV.

For the foregoing reasons, we affirm.

APPENDIX C

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 05-6911

[Filed March 22, 2007]

PEGGY WELSHANS WILLIAMSON,)
)
and)
)
VANESSA WELSHANS,)
Plaintiffs-Appellants,)
)
v.)
)
AETNA LIFE INSURANCE COMPANY,)
Defendant-Appellee.)
)

Appeal from the United States District Court for the Western District of Tennessee at Memphis.

JUDGMENT

Before: SILER, GILMAN, and GRIFFIN, Circuit Judges.

THIS CAUSE was heard on the record from the district court and was argued by counsel.

IN CONSIDERATION WHEREOF, it is ORDERED that the judgment of the district court is AFFIRMED.

ENTERED BY ORDER OF THE COURT

/s/_____

Leonard Green, Clerk

APPENDIX D

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

CASE NO: 2:04cv2851-B

[Filed November 21, 2005]

PEGGY WELSHANS WILLIAMSON)
)
and)
)
VANESSA WELSHANS,)
Plaintiffs,)
)
v.)
)
AETNA LIFE INSURANCE COMPANY,)
Defendant.)

DECISION BY COURT. This action came to consideration before the Court. The issues have been considered and a decision has been rendered.

IT IS SO ORDERED AND ADJUDGED that in accordance with the Order Granting Defendant's Motion For Summary Judgment entered on November 17, 2005, this cause is hereby dismissed and judgment is entered in favor of

the Defendant, Aetna Life Insurance Company, and against the Plaintiffs, Peggy Welshans Williamson and Vanessa Welshans.

APPROVED:

/s/
J. DANIEL BREEN
UNITED STATES DISTRICT COURT

/s/Thomas M. Gold
Clerk of Court

11/21/05
Date

/s/
(By) Deputy Clerk

APPENDIX E

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF
TENNESSEE
WESTERN DIVISION**

No. 04-2851 B

[Filed November 17, 2005]

PEGGY WELSHANS WILLIAMSON)
)
and)
)
VANESSA WELSHANS,)
Plaintiffs,)
)
v.)
)
AETNA LIFE INSURANCE CO.,)
Defendant.)

ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

Before the Court is the motion of the Defendant, Aetna Life Insurance Co. ("Aetna"), for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure. Plaintiffs, Peggy Williamson and Vanessa Welshans, originally brought this action for

common law breach of contract, and violation of the Tennessee Consumer Protection Act, codified at Tennessee Code Annotated § 47-18-104 *et seq.*, and the Tennessee "bad faith statute," codified at Tennessee Code Annotated § 56-7-105, in the Circuit Court of Shelby County, Tennessee. Specifically, Plaintiffs allege that Aetna wrongfully denied health insurance benefits for Williamson's daughter, Welshans, under an employee health plan provided to Williamson by her employer, General Agencies of the United Methodist Church ("General Agencies") and administered by the Defendant. On October 22, 2004, the Defendant removed the matter to this Court with jurisdiction predicated on diversity of citizenship under 28 U.S.C. § 1332. In the instant motion, Aetna seeks summary judgment as to all claims. For the reasons stated below, Defendant's motion is GRANTED.

BACKGROUND AND PROCEDURAL HISTORY

The following facts are undisputed unless otherwise noted. Plaintiff Peggy Welshans Williamson was employed by General Agencies from 1977 until she retired in 1995.[1] (Pl.'s Resp. Def.'s Mot. Summ. J. ("PL's Resp.") Ex. G, Dep. Peggy Welshans Williamson ("WilliamsonDep.") at 23, 25.) As an employee, Williamson was covered by General Agencies' group health insurance plan and, as part of her retirement,

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[1] Williamson continued working for General Agencies as a consultant following her retirement until the end of 1996. (Pl.'s Resp. Def.'s Mot. Summ. J. ("PL's Resp.") Ex. G, Dep. Peggy Welshans Williamson ("Williamson Dep.") at 25.)

she continued to be eligible for the benefits in place at the time she retired. (*Id.* at 42.) Williamson was a member of a task force at General Agencies that designed the employer's insurance plan and recommended that the Defendant be selected as the plan administrator. (*Id.* at 43 - 49.) Based on this recommendation, General Agencies' contracted with Aetna to administer its group health plan ("Plan") from January 1, 1995 through December 31, 2000.[2] (Amend. Compl. ¶10.)

Plaintiff Vanessa Welshans is Williamson's daughter. (Amend. Compl. ¶ 5.) Prior to 1986, Welshans was eligible for coverage under General Agencies' health insurance plan as a dependent child of her mother. (Amend. Compl. ¶ 24.) In May 1983, when Weshans was twenty-two years old, she was involved in a car wreck in which she sustained broken legs, a broken pelvis and a broken back. (Williamson Dep. at 40.) According to the Plaintiffs, as a result of the wreck, Welshans suffers from a lower extremity problem which impedes her ability to sit, stand, walk, climb stairs, or do any bending or squatting for a sustained period of time. (Pl.'s Resp. Ex. C at 2.) In 1986, after reaching the maximum age for coverage as a dependent child of Williamson, Welshans was provided continued coverage by Cigna, the prior administrator of General Agencies' health plan, as a "fully handicapped dependent" because of the injuries she sustained in the accident. (Amend. Compl. ¶ 18.) Welshans received coverage as a handicapped

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[2] Prior to January 1, 1995 Cigna administered General Agencies' group health plan. (Amend. Compl. ¶ 10.)

dependent from 1986 through 1995 under the terms of the plan with Cigna. (Id. at ¶ 19.)

While Welshans has not been employed since the accident, she has been a full-time student since 1994. (Pl.'s Resp. Ex. G, Dep. Vanessa Claire Welshans ("Welshans Dep.") at 19 - 21, 37.) In 1994, Welshans attended East Arkansas Community College in Wynne, Arkansas. In 1995, she transferred to Lambuth University in Jackson, Tennessee. (*Id.* at 19 - 20) After graduating from Lambuth University in 1997 with an undergraduate degree in history and sociology, Welshans enrolled at the University of Memphis in Memphis, Tennessee. (*Id.* at 20.) She earned a masters degree in American history from the University of Memphis in 2000 and has since continued her studies toward a doctorate degree in American History and Modem Europe. (*Id.* at 20.) At the time of her deposition in December 2002, Welshans expected to complete the doctoral program in 2004. (*Id.* at 21.)

Despite her injuries, Welshans is physically and mentally able to care for herself. (Pl.'s Resp. Ex. C at 2 and Welshans Dep. at 9 - 14.) She lived independently in Wynne, Arkansas while attending East Arkansas Community College from 1994 through 1995. (*Id.* at 14.) While attending Lambuth University from 1995 - 1998, Welshans occasionally lived with her mother. (*Id.* at 11 - 13.) Since 1998, she has lived alone in the Memphis and Collierville, Tennessee area. (*Id.* at 9 - 10.)

Welshans only source of income is the approximately $500 per month she has received in

Social Security Disability payments since 1984.[3] (Welshans Dep. at 42.) Welshans transfers money from Williamson's bank account to her own account each month as needed to meet her living expenses including, rent, bills, and food. (Welshans Dep. at 45 - 46.)

Williamson and Welshans participated in the indemnity provisions of General Agencies' group health plan during the time in which Aetna served as the administrator. (Def.'s Mot. Ex.. 4 Decl. Denise Paradis ("Paradis Decl.") ¶ 6.) Pursuant to these provisions, the insured was responsible for submission of claims to Aetna. (Def.'s Mot. Ex. 5 ("Plan Booklet") at 26.) After the insured satisfied a $250 calendar year deductible, Aetna was responsible for reimbursement of eighty percent of the "reasonable and customary costs (R&C) of most covered expenses." (Plan Booklet at 26.) The insured was responsible for payment of the remaining twenty percent of the R&C costs and any other non-covered expenses, such as those exceeding the R&C limits or for services excluded from the Plan's coverage. (*Id.*) If the insured's "out of pocket"expenses, excluding the deductible, exceeded $1,500 in a calendar year, Aetna would reimburse one-hundred percent of R&C costs of covered expenses. (*Id.*) The Plan listed services and products that were excluded

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[3] Welshans also receives income as a joint owner of a farm. At the time of her deposition, all farm proceeds were directed to the payment of the mortgage on the farm. As such, Welshans did not receive any disposable income as a result of her ownership. (Welshans Dep. at 42 - 44.)

from coverage. (Def.'s Mot. Ex. 4B ("Summary Plan Description") at 19 - 22 and Plan Booklet at 35 - 37.)

In January 1995, when Aetna began administering General Agencies' health plan, Welshans was thirty-four years of age. (Welshans Dep. at 9.) It is undisputed that, because of her age, Welshans was ineligible for coverage as a dependent child of Williamson during the time at issue in this action. (Welshans Dep. at 9.) However, the Plan provided that "Health Insurance Coverage for [the insured's] fully handicapped dependent may be continued past the maximum age for a dependent child, if he or she has not been issued a personal medical conversion policy." (Summary Plan Description at 29.) A person is qualified as a fully handicapped dependent if he or she "is not able to earn his or her own living because of mental retardation or physical handicap which started prior to the date he or she reaches the maximum age for dependents; and he or she chiefly depends on [the insured] or another care provider for support." (*Id.*) Dependence on another care provider is defined as requiring a "Community Integrated Living Arrangement, group home supervised apartment or other residential services licensed or certified by the Department of Mental Health and Developmental Disabilities, the Department of Public Health or the Department of Public Aid." (*Id.*) According to the Plan, once established, coverage for a fully handicapped dependent will continue until any one of the following occurrences: (1) "cessation of the handicap and dependency;" (2) "[t]he end of a sixty day period from the date Aetna requests proof of the continuation of the handicap and dependency, if proof is not provided within the 60 day period;" or (3) "Termination of

Dependent Coverage as to [the insured's] dependent for any reason other than reaching the maximum age." (*Id.*) The Plan further provides that Aetna "may request proof of the continuation of the handicap as often as it may reasonably require, but not before two months prior to the dependent reaching the maximum age." (*Id.*)

When it took over administration of General Agencies' health plan in 1995, Aetna initially rejected medical claims submitted by Welshans and other children of insureds, whom Cigna had previously provided coverage as handicapped dependents, because of a computer error. (Williamson Dep. at 113 - 116; Def.'s Mot. Ex. 1 at 58; PL's Mot. Ex. I, Dep. Deborah Dee Spencer ("Spencer Dep.") at 33 - 35.) In response to the problem, Aetna instituted a policy by which it would "cover all incapacitated dependents without question" for the calendar year 1995. (Pl.'s Resp. Ex. E at 1547.) However, Aetna expected to "return to normal procedures to determine whether an incapacitated dependent is eligible to remain on the [General Agencies] plan" by January 1, 1996, at which time, dependents could be terminated if they did not meet the Plan's criteria for eligibility. (*Id.*) Consistent with this policy, Welshans was provided coverage as a handicapped dependent of Williamson in 1995 without

an eligibility determination.[4] (Spencer Dep. at 48-49 and Williamson Dep. at 116.)

On July 26, 1996, Aetna first denied Welshans coverage as a handicapped dependent. (Pl.'s Resp. Ex. A at 1.) Based on a review of materials submitted by Williamson, Aetna determined that she was "not handicapped as described in the plan because the physical limitations described do not seem to be of a severity to preclude full time employment." (*Id.*) Williamson sent a second request for continuation of coverage in August 1996 along with a statement from Welshans' doctor, Dr. Thomas Limbird, describing her injuries in detail and opining that she was unable to maintain employment. (Pl.'s Resp. Ex. C and Ex. E at 1098 - 1102.) Aetna requested additional information regarding Welshans' dependency and marital status from Williamson in a letter dated September 14, 1996. (Pl.'s Resp. Ex. E at 1149 - 50.) It is unclear from the record whether subsequent determinations were made as to Welshan's eligibility in 1996, 1997 or 1998, or whether a settlement or other agreement was entered into by Aetna and the Plaintiffs through which Aetna agreed to provide coverage as a handicapped dependent.[5] Regardless of the method, Welshans was

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[4] Plaintiffs do not dispute whether Welshans was provided coverage as a handicapped dependent in 1995. However, the non-payment of some individual claims alleged by Defendant to have been made on bases other than Welshans' status as a handicapped dependent during 1995 are disputed. (Pl.'s Resp. Def.'s Facts ¶ 12 and Williamson Dep. at 116 - 117.)

[5] Plaintiffs allege that Aetna agreed to pay all claims from 1996 though 1998 as part of a settlement of a lawsuit brought by

provided coverage under General Agencies' health plan during those years as demonstrated by the Explanations of Benefits ("EOB's") issued by Aetna regarding claims submitted by Plaintiffs for the period in question.[6] (Def.'s Mot. Ex. 7 and Pl.'s Resp. Ex. E.)

Plaintiffs against Aetna in 1996. (Amend. Compl. ¶ 38 and Pl.'s Resp. Def.'s Facts ¶ 37 - 40.) Defendant neither admits nor denies the existence of such an agreement, but notes correctly that Plaintiffs have not provided any documentary evidence in support of their allegations. (Def.'s Resp. PL's Resp. Def.'s Facts ¶ 40.)

Deposition testimony by Deborah Spencer indicates that Aetna did make determinations of eligibility regarding Welshans in 1996 and 1997, but does not definitively state whether these determinations were made pursuant to an agreement with Plaintiffs or based solely on a determination by Aetna. (Spencer Dep. at 49, 58 - 59.) The Court notes a letter dated December 4, 1997 through which Aetna notified Williamson that, based on the information she recently submitted, Welshans would be provided coverage. (Spencer Dep. Ex. 4.) Spencer indicated that no determination was made in 1998. (*Id.* at 83.) The Court is aware of no documentary evidence of a review procedure or notice to Plaintiffs regarding eligibility determinations in the record for the period of 1996 - 1998, other than the letter dated December 4, 1997.

[6] Plaintiffs do not dispute that Welshans was retroactively provided coverage under General Agencies' health plan in 1998 for claims submitted from 1996 through 1998. However, the handling of some individual claims on bases other than Welshans' status as a handicapped dependent during this period are disputed.(Amend. Compl. Ex. 4.)

On October 8, 1999, Aetna requested verification of Welshans' status as a handicapped dependent. (Williamson Dep. Ex. 5.) On November 8, 1999, Aetna directed a second request to Williamson for incapacitated child information. (Id. at Ex. 7.) It is unclear from the record whether Plaintiffs responded to these requests.[7] However, the parties do not dispute that Aetna terminated Welshans' coverage in 1999. (Pl.'s Ex. E at 1163.)

On January 22, 1999, Plaintiffs filed separate complaints in the United States District Court for the Middle District of Tennessee to recover damages for breach of contract, and violations of both the Tennessee Consumer Protection Act, Tenn. Code Ann. § 47-18-104, and the Tennessee "bad faith" statute, Tenn. Code Ann. § 56-7-105, as a result of Defendant's

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[7] Defendant Aetna claims that Williamson did not respond to these requests for information. (Def.'s Mot. ¶ 14 and Spencer Dep. at 84.) In support, Aetna offers the deposition testimony of Deborah Spencer, an Aetna employee during the time at issue in this action, as well as internal documents from Aetna noting the non-receipt of the requested information.

Williamson, while unable to recall the specific date or produce copies, alleges that, in general, she responded to all requests for information by Aetna. (Williamson Dep. at 92 - 96.) However, Plaintiffs have not offered any evidence to support the applicability of this general statement to the specific request at issue. Rather, Plaintiffs allege in their response to Defendant's Facts, that a response was not required because Aetna already had in its possession sufficient information from which to make a determination. (Pl.'s Resp. Def.'s Facts ¶ 14.)

alleged failure to pay Welshans's medical claims.[8] On September 22, 2003, during a bench trial, Plaintiffs voluntarily non-suited their case and the court entered an order dismissing the action without prejudice. Subsequently, on September 15, 2004, Plaintiffs filed the instant complaint in the Circuit Court of Shelby County, Tennessee which was amended with a filing on September 20, 2004. The Defendant removed the action to this Court based on diversity of citizenship

STANDARD OF REVIEW

Rule 56(c) provides that a

> . . .judgment . . . shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.

Fed. R. Civ. P. 56(c); *see Celotex Corp. v. Catrett*, 477 US. 317, 322, 106 S.Ct. 2548, 2552, 91 L.Ed.2d 265 (1986); *Canderm Pharmacal. Ltd. v. Elder Pharmaceuticals, Inc.*, 862 F.2d 597, 601 (6th Cir. 1988). In reviewing a motion for summary judgment, the evidence must be viewed in the light most favorable to the nonmoving party. *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574,587, 106 S.Ct. 1348, 1356,89 L.Ed.2d 538 (1986).

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[8] Williamson and Welshans' complaints were consolidated by the state court on March 13, 2000.

When the motion is supported by documentary proof such as depositions and affidavits, the nonmoving party may not rest on his pleadings but, rather, must present some "specific facts showing that there is a genuine issue for trial." *Celotex*, 477 U.S. at 324, 106 S.Ct. at 2553. It is not sufficient "simply [to] show that there is some metaphysical doubt as to the material facts." *Matsushita Elec. Indus. Co.*, 475 U.S. at 586, 106 S.Ct. at 1356. These facts must be more than a scintilla of evidence and must meet the standard of whether a reasonable juror could find by a preponderance of the evidence that the nonmoving party is entitled to a verdict. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 252, 106 S.Ct. 2505, 2512, 91 L.Ed.2d 202 (1986). "[T]he mere existence of *some* alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no *genuine* issue of *material* fact." *Id.* at 247 - 48, 106 S.Ct. at 2510 (emphasis in original). Summary judgment must be entered "against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Celotex*, 477 U.S. at 322, 106 S.Ct. at 2552. In this circuit, "this requires the nonmoving party to 'put up or shut up' [on] the critical issues of [his] asserted causes of action." *Saratoga Capital, Inc.*, 920 F. Supp. 840, 847 (W.D. Tenn. 1995) (citing *Street v. J.C. Bradford & Co.*, 886 F.2d 1472, 1478 (6th Cir. 1989)). "If the adverse party does not so respond, summary judgment, if appropriate, shall be entered against the adverse party." Fed. R. Civ. P. 56(e). Finally, the "judge may not make credibility determinations or

weigh the evidence." *Adams v. Metiva*, 31 F.3d 375, 379 (6th Cir. 1994).

ANALYSIS

I. Tennessee Consumer Protection Act

The Tennessee Consumer Protection Act ("TCPA") provides consumers with a private right of action for any "[u]nfair or deceptive acts or practices affecting the conduct of any trade or commerce." Tenn.Code Ann. § 47-18-104(a) & -109(a)(l); *see also Menuskin v. Williams*, 145 F.3d 755, at 767 (6th Cir. 1998). "The main purpose of the Act is to protect consumers, and it must be liberally construed to affect that purpose." *Gaston v. Tennessee Farmers Mut. Ins. Co.*, 120 S.W.3d 815, 822 (Tenn. 2003). Included in the statute is a non-exhaustive list of thirty-two specific unfair or deceptive acts or practices which are prohibited, as well as a catch-all provision proscribing "[e]ngaging in any other act which is deceptive to the consumer or to any other person." Tenn. Code Ann. § 47-18-104(b)(27). While not included in the specific list, the Tennessee courts have concluded that the acts and practices of insurance companies are within the scope of the TCPA. *Myint v. Allstate Ins. Co.*, 970 S.W.2d 920, 925 - 26 (Tenn. 1998) (holding that the TCPA applies to the initial issuance of an insurance policy); *Newman v. Allstate Ins. Co.*, 42 S.W.3d 920, 924 (Tenn. Ct. App. 2000) (citing *Myint* when applying the TCPA to an insurance coverage dispute arising after the issuance of the policy); *see also Sparks v. Allstate Ins. Co.*, 98 F.Supp. 2d 933, 937 (W.D. Tenn. 2000) (relying on *Myint* hold that the TCPA applies to claims handling procedures of insurance companies).

"In order to recover under the TCPA, the Plaintiff[s] must prove: (1) that the defendant engaged in an unfair or deceptive act or practice declared unlawful by the TCPA; and (2) that the defendant's conduct caused an 'ascertainable loss of money or property, real, personal, or mixed, or any other article, commodity, or thing of value wherever situated....'" *Tucker v. Sierra Builders*, No. M2003 - 02372 - COA - R3 - CV, 2005 WL 1021675, *4 (Tenn. Ct. App. April 29, 2005) (quoting Tenn. Code Ann. § 47-18-109(a)(1)). "The defendant's conduct need not be willful or even knowing, but if it is, the TCPA permits the trial court to award treble damages." *Id.*

The Defendant argues that Plaintiffs' claim under the TCPA must fail because they have not shown that Aetna has engaged in any deceptive or unfair act nor that they have suffered an ascertainable loss of money. (Def.'s Mot. at 8.) Rather than alleging unfair or deceptive acts, Aetna asserts that Plaintiffs merely contest the correctness of claim processing decisions and have offered no evidence to demonstrate that any claims were processed in a manner inconsistent with the terms of the Plan. (*Id.* at 9.) In response, Plaintiffs argue that in the handling of Welshans' claims,

> Aetna's conflicting, sequential reasons for denials, refusal to apply the plain language of the Plan, disregard for uncontroverted medical evidence in its files, continuously shifting explanations for why claims were not paid, refusal to pay the claims listed in Exhibit 4, and ultimate return to its original determination that Welshans was somehow not "handicapped

> dependent" as that term is defined in the Plan, were deceptive . . and otherwise unfair.

(Amend. Compl. ¶ 59.) Specifically, Plaintiffs maintain that Aetna acted deceptively and unfairly in violation of the TCPA by misrepresenting the terms of the Plan and denying claims without investigation. (*Id.* ¶¶ 60, 61.) As a result of Defendant's actions, Plaintiffs alleged that they have suffered damages in the amount of $74,999. (*Id.* ¶ 63.)

In support of their claims, Plaintiffs rely on evidence of multiple requests from Aetna for verification of Welshans' status as a fully handicapped dependent. In addition, Plaintiffs offer a non-exhaustive list of more than 180 claims alleged to have been filed with Aetna and wrongfully denied spanning a time period of March 7, 1995 through December 3 1, 2000. (Amend. Compl. Ex. 4.) Plaintiffs have made no effort to inform the Court of the basis for their allegation that any one of the listed decisions by Aetna was unfair or deceptive. Upon review of Plaintiffs' list of wrongfully denied claims, the Court notes that many of the listed claims reflect a reimbursement by Aetna. *(see e.g.* Amend. Compl. Ex. 4, claim dated March 22, 1995 reflects a charge of $25 of which Aetna reimbursed $20.) With the exception of the name of the provider and the date and amount of the claim, Plaintiffs offer no other information or explanation from which this Court can infer deception or unfairness.[9] While Plaintiffs have included with

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[9] The list does not provide information relevant to such an inference such as (1) when the claim was submitted to Aetna; (2)

their response to Defendant's motion EOB's for many of the listed claims, they have not provided any argument as to how the explanation of Aetna's response to submitted claims amounts to a departure from the Plan, much less any misrepresentation, or any other unfairness or deception. *See Bookman v. Shubzda*, 945 F. Supp. 999, 1004 (N.D. Tex. 1996) (noting that a district court does not have a duty "to survey the entire record in search of evidence to support the non- movant's opposition.")

The only denials which Plaintiff allege were wrongful with some specificity are those based on Welshan's eligibility for coverage as a handicapped dependent. "Erroneous denial of a claim, however, unaccompanied by deceit or other misleading conduct, does not constitute deception or unfairness." *Hamer v. Harris*, No. M2002-00220-COA-R3-CV, 2002 WL 31469213, *1 (Tenn. Ct. App. Feb. 18, 2002) (citing *Myint*). In *Myint v. Allstate Ins. Co.*, the Tennessee Supreme Court considered application of the TCPA to a suit against Allstate Insurance Company based upon a denial of coverage under a property insurance policy. *Myint*, 970 S.W.2d at 924-26. Despite the fact that a jury determined that Allstate was liable for coverage under the applicable policy, the court affirmed summary dismissal of the TCPA claim, noting that,

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what services or products the claim was submitted in regard to; (3) whether the service or product was eligible for coverage as represented by Aetna in the Plan; (4) the R&C cost for such service or product as represented by Aetna in the Plan; and (5) the response, if any, from the Defendant in regard to the submission, including, the reason provided for the response.

"the record reveals no evidence of an attempt by Allstate to violate the terms of the policy, deceive the Myints about the terms of the policy, or otherwise act unfairly. It is apparent that the denial of the Myints' claim was Allstate's *reaction to circumstances which Allstate believed to be suspicious.* Consequently, Allstate's conduct does not fall within the purview of the Tennessee Consumer Protection Act[.]" *Id.* at 926 (emphasis added).

In the instant case, it is undisputed that the Plan provides Aetna with the right to request proof of the continuation of Welshans' handicap "as often as it may reasonably require." (Summary Plan Description at 29.) Further, it is clear from the facts that, whether or not Welshans' physical condition changed, her living conditions and lifestyle did change significantly during the time Aetna administered General Agencies' health plan. Specifically, in 1994, Welshans enrolled in a full time education program which continued through the term of Aetna's administration. Further, Welshans, who had previously lived with Williamson, began living independently, often in different cities than her mother. From these facts alone, it is reasonable for Aetna to have suspected that Welshans' status as a fully handicapped dependent incapable of making a living for herself may have changed. Whether or not this conclusion was correct, the circumstances surrounding Welshans' dependency provided a good faith basis for inquiry and the clear terms of the Plan entitled Aetna to do so. *Ginn v. American Heritage Life Ins. Co.*, 2004 WL 3008801, *11 (Tenn. Ct. App. 2004) (finding no evidence to support a verdict under the TCPA where the "only reason [the defendant] claimed plaintiff was not entitled to the [life insurance policy]

proceeds was its good faith belief, albeit mistaken, that Plaintiff materially misrepresented her husband's health"); *see also Hamer*, 2002 WL 31469213 at *2 (finding no violation of the TCPA where defendant refused to perform repairs because he determined it was not his responsibility under the terms of the contract even though that determination was later adjudged erroneous). As Plaintiffs have failed to present evidence sufficient to establish that Defendant engaged in deceptive or unfair acts, the Court GRANTS the Defendant's motion for summary judgment on Plaintiffs' TCPA claim.

II. Tennessee "bad faith" Statute

The Tennessee "bad faith" statute provides that insurance companies

> in all cases in which a loss occurs and they refuse to pay the loss within sixty (60) days after a demand has been made by the holder of the policy. . . on which the loss occurred, shall be liable to pay the holder of the policy . . ., in addition to the loss and interest thereon, a sum not exceeding twenty-five percent (25%) on the liability for the loss; provided, that it is made to appear to the court or jury trying the case that the *refusal to pay the loss was not in good faith*, and that such failure to pay inflicted additional expense, loss, or injury, including attorneys fees upon the holder of the policy . . .

Tenn. Code Ann. § 56-7-105 (emphasis added). The statute is penal in nature and must be strictly construed. *Niagra Fire Ins. Co. v. Bryan & Heweley*, 195 F.2d 154, 156 (6th Cir. 1952). In order to establish

a claim under the statute, Plaintiffs must demonstrate (1) that the insurance policy, by its terms, became due and payable; (2) that a formal demand for payment was made; (3) that Plaintiffs waited sixty days after making demand before filing suit; and (4) that Aetna's refusal to pay was not in good faith. *Palmer v. Nationwide Mut. Fire Ins. Co.*, 723 S.W.2d 124, 126 (Tenn. Ct. App. 1986). The insured bears the burden of proving bad faith on the part of the insurer in denying payment. *Id.* "A penalty is not appropriate when the insurer's refusal to pay rests on legitimate and substantial legal grounds." *Tyber v. Great Central Ins. Co.*, 572 F.2d 562, 564 (6th Cir. 1978).

Defendant bases its motion for summary judgment on the fourth prong, namely that Plaintiffs' have failed to offer any evidence of bad faith by Aetna. Plaintiffs assert that Aetna refused without good faith justification to pay any of the claims listed in Exhibit 4 to their complaint. (Amend. Compl. ¶ 69.) Aetna contends in response, however, that all refusals to pay were based upon legitimate grounds for disputing the claims consistent with the Plan. (Def.'s Mot. at 12.) In support of it's position, Aetna offers its own list of the claims disputed by Plaintiffs which, unlike Plaintiffs' list, includes the reason specified on the relevant EOB for the action taken on the claim. (Def.'s Mot. Ex. 8.) Aetna denied all or part of Plaintiff's claims for reasons such as (1) the services or products were not covered expenses; (2) the charges submitted exceeded the R&C costs allowed under the Plan; (3) the claims were not timely submitted; (4) the deductible was not yet satisfied; (5) the service or product was not medically necessary; or (6) Welshans was not eligible for coverage because she exceeded the allowable age

for a dependent and/or was terminated from coverage. (*Id.* and Pl.'s Resp. Ex. R.) In other cases, Aetna paid eighty percent or one-hundred percent of the claim as submitted. (*Id.*) The Court will address the denial of claims on the basis of Welshans eligibility for coverage separately from those on the basis of the provisions of the Plan.

Regarding the denial of claims pursuant to provisions of the Plan unrelated to Welshans' eligibility for coverage, Plaintiffs have failed to set forth any argument to support an inference that the reasons provided by the Defendant for its response to their claims, grounded facially in the express terms of the policy, were not valid. "The bad faith penalty is not recoverable in every refusal of an insurance company to pay a loss. An insurance company is entitled to rely upon available defenses and refuse payment if there is substantial legal grounds that the policy does not afford coverage for the alleged loss." *Nelms v. Tennessee Farmers Mut. Ins. Co.*, 613 S.W.2d 481, 484 (Tenn. Ct. App. 1978). While Plaintiffs may dispute the resolution of the claims, they have offered no evidence from which this Court can infer bad faith on the part of the Defendant.

Regarding those claims denied on the basis of Welshans' eligibility in 1999 and 2000, Defendant maintains that, consistent with its rights under the Plan, coverage for Welshans was terminated at the end of a sixty day period after which it requested information to verify Welshans continued eligibility for coverage. (Def.'s Mot. at 13; Pl.'s Resp. Ex. E at 1159-63; Spencer Dep. at 83 - 85.) Aetna contends that it never received the requested information, thus,

consistent with the policy, Welshans was terminated. (*Id.*)

Plaintiffs do not dispute that the Plan permitted Aetna to request information regarding Welshans condition as reasonably required to determine her continued eligibility for coverage as a handicapped dependent. Rather, they maintain that Aetna's requests were unreasonable because they had previously supplied information which was sufficient to make the determination and which indicated that Welshans' condition was unlikely to change.[10] (Pl.'s

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[10] While not relied upon in Plaintiffs' response to the instant motion, the deposition testimony of Williamson addressed Plaintiffs' response to Aetna's requests:

> Q: . . . Now, you're indicating that every time you received these forms you filled them out and sent them back, is that correct?
>
> A: Yes.
>
> Q: Okay, did you keep copies of the forms?
>
> A: I doubt it. I don't know. I don't know. . .
>
> .....
>
> Q: Okay. Do you have any recollection of filling out the forms in 1999?
>
> A: Yes, we filled out forms in 1999, I know we did.
>
> Q: Okay, do you know when you did that?
>
> A: No, I just know when we were requested to do that, we did it
>
> .....
>
> A: No, I am just saying to you that any time we received a request to do some kind of action from Aetna, we did it, no matter how insane their request was.

Resp. Def.'s Facts ¶ 14.) Specifically, Plaintiffs rely on the statement submitted by Dr. Thomas Limbird on August 9, 1996 describing Welshans' medical condition, his prognosis that her condition was unlikely to improve, and his opinion that Welshans

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Despite this generalized contention by Williamson, Plaintiffs have pointed to no evidence in the record to counter Defendant's allegation that no response was received. In contrast, the Defendant offers the deposition testimony of Deborah Dee Spencer, an Aetna employee, that no eligibility determination was made in 1999 because Aetna did not receive the requested documentation. (Spencer Dep. at 83 - 84.) In addition, Defendant offers two letters, dated October 8, 1999 and November 8, 1999, directed to Williamson requesting the information, the latter of which indicates that it is a "second request." (Pl.'s Resp. Ex. E at 1159 - 63). While she is unable to recall the specific letter, Williamson concedes that the letters were addressed to her then current address. (Williamson Dep. at 90 - 96.) In addition, Defendant has offered an internal Aetna document dated November 16, 1999 indicating that Ms. Williamson was advised by phone to supply the requested information. (*Id.* at 1163.) The same document includes an entry dated December 17, 1999 indicating that, because no information was received, Welshans coverage was terminated.

In the face of Defendant's documentary evidence demonstrating that Plaintiffs did not provide the requested information, it is incumbent on the Plaintiffs to bring forth specific facts showing that there is an issue at trual. *Celotex*, 477 U.S. at 324, 106 S. Ct. At 2553. The Court concludes that the Plaintiffs' generalized statement of compliance is not sufficient to meet this burden.

was unable to maintain employment. (Pl.'s Resp. Ex. C.). Because Aetna already had this information, Plaintiffs maintain that the requests, and subsequent denial of claims, were made in bad faith. (Pl.'s Resp. Def.'s Facts ¶13.)

The Court finds Plaintiffs' position to be without merit. The plain language of the Plan permits the inquiry made by Aetna and provides for termination of coverage in the event that the insured does not comply.[11] As noted above, during the period of 1994 through 1999, Welshans began and successfully maintained status as a full time student. In addition, in 1998 she moved from Jackson, Tennessee to Memphis, Tennessee where she lived apart from Williamson. These changed circumstances create a reasonable basis from which Aetna could question whether Welshans continued to be unable to earn her living or chiefly depend on Williamson for support. (Summary Plan Description at 29.); *see also Nelms v. Tennessee Farmers Mutual Ins. Co.*, 613 S.W.2d at 484 (reversing the jury's award of a bad faith penalty after concluding there were "valid reasons for the insurance company to question the loss"). The Court also notes that Limbird's statement was first submitted to Aetna in 1996. While his prognosis was that Welshans condition was unlikely to change, a current medical

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[11] The Plan provides that coverage of a handicapped dependent will cease upon "[t]he end of a 60 day period from the date Aetna requests *proof of the continuation of the handicap and dependency*, if proof is not provided within the 60 day period." (Summary Plan Description at 29.) (emphasis added)

evaluation after three years is not unreasonable.[12] Further, while Limbird's statement regarding Welshan's physical condition may well have been valid in 1999, it did not speak to Welshans' dependency status. In light of Welshans' changed circumstances and the express language of the Plan, Defendant's request for eligibility information was reasonable. Because Plaintiffs have failed to offer any evidence that they complied with the request as required under the terms of the Plan, the Court finds that Aetna had substantial legal grounds for termination of the policy. As such, Defendant's motion for summary judgment is GRANTED as to Plaintiffs' claim for the "bad faith" penalty.

III. Breach of Contract

Under Tennessee law, insurance contracts are to be interpreted in the same way as other types of contracts. *Merrimack Mut. Fire Ins. Co. v. Batts*, 59 S.W.3d 142, 148 (Tenn. Ct. App. 2001), *reh'g of denial of app. den.* (Dec. 27, 2001). The language of an insurance policy is to be "given its plain and ordinary meaning." *Tennessee Farmers Mut. Ins. Co. v. Tait*, No. 99-6578, 2001 WL 1216963, at *2 (6th Cir. Oct. 4, 2001) (per curiam) (applying Tennessee law) (citations omitted). The court must read the policy as a layperson would. *Davidson Hotel Co. v. St. Paul Fire & Marine Ins. Co.*, 136 F. Supp. 2d 901, 905 (W.D. Tenn. 2001).

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[12] Plaintiffs' have provided no evidence of the submission of any medical evaluation other than that of Dr. Limbird in 1996.

"Where there is an ambiguity or uncertainty with regards to the terms of an insurance policy, the court must interpret the terms strictly against the drafter of the policy." *Tennessee Farmers Mut. Ins. Co.*, 2001 WL 1216963, at *2 (citing *NSA DBA Benefit Plan, Inc. v. Connecticut Gen. Life Ins. Co.*, 968 S.W.2d 791, 795 (Tenn. Ct. App. 1997)). If the language of the policy is unambiguous the court "must interpret it as written." *Public Employees Benefit Servs. Corp. v. Parminter*, 60 S.W.3d 833, 837 (Tenn. Ct. App. 2001), *app. den.* (Sept. 17, 2001) (citation omitted). The court is not at liberty to rewrite an insurance contract simply because it does not favor its terms and must not force constructions that would render provisions ineffective or extend provisions beyond their intended scope. *Merrimack Mut. Fire Ins. Co.*, 59 S.W.3d at 148.

Plaintiffs argue that summary judgment is inappropriate on their breach of contract claim for a myriad of reasons, the central nexus of which seems to be Aetna's allegedly wrongful processing of claims between 1995 and 1998, during the period Welshans was provided coverage, as well as Aetna's denial of claims after her coverage was terminated in 1999. The Court will, again, address these issues separately. The Defendant asserts that it processed Welshans' claims from 1995 through 1998 in accordance with the terms of the Plan. In support, Aetna has offered a list of Welshans' claims during this period along with the action taken by Aetna and the reason for that action as specified in the EOB. (Def.'s Mot. Ex. 8.) Defendant argues that all explanations offered by Aetna for the actions taken are based in the plain language of the Plan's provisions and exclusions. (Def.'s Mot. at 15.) Plaintiffs have offered no evidence or argument in

response to Aetna's assertions to demonstrate otherwise. Furthermore, from the of the Plan's provisions and exclusions. (Def.'s Mot. at 15.) Plaintiffs have offered no evidence or argument in response to Aetna's assertions to demonstrate otherwise. Furthermore, from the information provided by Plaintiffs, the Court is unable to make any determination regarding the validity of Aetna's actions under the contract. Plaintiffs' list of claims provides only the date, provider name, amount claimed and response by Aetna. (Amend. Compl. Ex. 4.) Because the Plaintiffs have not provided any information or argument to the Court regarding the basis for the claim and how Aetna's action departed from the terms of the Plan, the Court is unable to make any determination as to whether the claim for the service or product was wrongfully processed. Where Plaintiffs have not supplied an argument for breach of contract on any of the more than 180 claims listed, the Court will not endeavor to do it for them. *See Skotak v. Tenneco Resins, Inc.*, 953 F.2d 909, 916 n. 7 (5th Cir. 1992) ("Rule 56 does not impose upon the district court a duty to sift through the record in search of evidence to support a party's opposition to summary judgment . . . Rule 56 allocates that duty to the opponent of the motion, who is required to point out the evidence, albeit evidence that is already in the record, that creates an issue of fact.").

Aetna maintains that the termination of Welshans' coverage and subsequent denial of claims on that basis was also made pursuant to the plain language of the Plan. (Def.'s Mot. at 17-18.) As noted above, the Plan provided Aetna with the authority to request proof of Welshans' continued handicap and dependency as it

may "reasonably require" to make determinations regarding her eligibility for coverage. (Summary Plan Description at 29.) As the Court has already determined that Aetna's requests for such information in 1999 were reasonable in light of the circumstances, the only remaining issue is whether Aetna was within its contractual rights to terminate Welshan's coverage in 1999. The contract provides Aetna with authority to terminate at "[t]he end of a 60 day period from the date Aetna requests proof of the continuation of the handicap and dependency, if proof is not provided within the 60 day period." The uncontroverted evidence demonstrates that Aetna requested such proof on October 8, 1999. Defendant avers that Plaintiffs failed to respond to the request. Plaintiffs have not directed the Court to any evidence to demonstrate that this fact is in dispute. Accordingly, pursuant to the terms of the contract, Aetna could rightfully terminate Welshans' coverage on December 9, 1999.

Finally, the Court notes that Plaintiffs' response in opposition to summary judgment mentions several other arguments, including Defendant's failure to investigate claims, and "continuous[] reinterpreti[on of] the definition of 'handicapped dependent' in a manner inconsistent with the Plan." Because Plaintiffs have set forth no facts or specific arguments in support of these contentions, the Court finds that they are without merit.

CONCLUSION

Based on the foregoing, this matter is DISMISSED and the Clerk of Court is directed to enter judgment in favor of the Defendant.

IT IS SO ORDERED this 16th day of November 2005.

/s/
J. DANIEL BREEN
UNITED STATES DISTRICT JUDGE

APPENDIX F

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF TENNESSEE WESTERN DIVISION

Case No. _____

[October 22, 2004]

PEGGY WELSHANS WILLIAMSON)
)
and)
)
VANESSA WELSHANS,)
Plaintiffs,)
)
v.)
)
AETNA LIFE INSURANCE CO.,)
Defendant.)
)

NOTICE OF REMOVAL

Defendant Aetna Lire Insurance Company (hereinafter referred to as "Aetna"), by and through its undersigned attorneys, and pursuant to 28 U.S.C. § 1332 and 1441(a) and (b), hereby files this Notice of Removal in the above-captioned action.

A. Procedural History of The Dispute

On January 22, 1999, each of the Plaintiffs separately filed essentially identical lawsuits in the United States District Court for the Middle District of Tennessee in Nashville against then co-Defendants Aetna and the General Commission on Communications d/b/a United Methodist Communications ("UMCom"), alleging that both Defendants had conspired against them to deprive them of insurance benefits under a health insurance plan purchased by UMCom and administered by Aetna. Plaintiffs claimed that the failure to pay certain of Plaintiff Welshans' insurance claims constituted a breach of contract, and a violation of both the Tennessee Consumer Protection Act, TENN. CODE ANN. § 47-18-101 *et seq.*, and Tennessee's "bad faith" statute, TENN. CODE ANN. § 56-7-105. Defendants timely filed their answers to the respective Complaints, denying Plaintiffs' allegations. Thereafter, on March 13, 2000, the Court entered an Order consolidating both cases under Case No. 3-99-0061.

During the next eighteen (18) months, through a series of case management conferences with the Court, the parties attempted to develop Plaintiffs' claims at issue in the lawsuit. By Order entered September 27, 2001, Plaintiffs voluntarily dismissed their claims against UMCom, and proceeded only against Aetna. Thereafter, on February 25, 2002 Plaintiffs filed an Amended Complaint, essentially restating their claims against Aetna. The parties continued to engage in discovery and exchange documents related to Plaintiffs' claims. On September 10, 2002 the parties

participated in a Court-sponsored settlement conference, but were unable to reach a settlement.

The parties completed discovery and Aetna filed a motion for summary judgment on all of Plaintiffs' claims on February 28, 2003. On July 2, 2003 the Court summarily denied Aetna's motion, stating only that factual disputes existed with respect to Plaintiffs' claims but without identifying or in any way expounding upon which material facts or categories of facts were disputed. The case proceeded to bench trial on September 22, 2003. During cross-examination of Plaintiff Williamson, the first witness called, the Court called *sua sponte* stopped testimony after Plaintiff Williamson repeatedly failed to adequately answer questions regard her alleged damages. The Court then instructed Plaintiffs in open court that they would face immediate dismissal of their case if they were unable to prove damages, and called a recess. Upon returning from the recess, Plaintiffs voluntarily non-suited their case.

B. The Present Lawsuit

On September 15, 2004, Plaintiffs filed the present lawsuit against Aetna in state court, which is essentially identical to the previous lawsuit filed in 1999. Plaintiffs admit that this present lawsuit asserts precisely the same claims against Aetna as did their previous lawsuit. (First Am. Compl. ¶ 4). Aetna now removes upon the following grounds:

1. A civil action was commenced on September 15, 2004, and is now pending in the Circuit Court of Tennessee for the Thirtieth Judicial District at

Memphis, Case Number CT-005301-04 (Div. 4), wherein Peggy Welshans Williamson ("Williamson") and Vanessa Welshans ("Welshans") are the Plaintiffs and Aetna is the Defendant. Plaintiffs' original Complaint was filed on September 15, 2004, and Plaintiffs filed a First Amended Complaint on September 20, 2004. According to the records of the state court wherein this action was originally filed, Plaintiffs served the Complaint and the First Amended Complaint by certified mail c/o Paula A. Flowers, Tennessee Insurance Commissioner, and that the documents were received on September 24, 2004. Thereafter, Aetna received a copy of the Complaint, First Amended Complaint and Summons on October 18, 2004, when the Tennessee Insurance Commission forwarded the pleadings to Aetna's registered agent for service of process. The Complaint, First Amended Complaint and Summons are the only process, pleadings or orders served upon Aetna. (All are attached hereto as Exhibit 1).

2. In this action, Plaintiffs sue Defendant for all relief to which they may be entitled, including all actual damages; a twenty-five percent (25%) penalty on all sums recovered under Tennessee's "bad faith" statute, TENN. CODE ANN. § 56-7-105; an amount equal to treble their actual damages under the Tennessee Consumer Protection Act, TENN. CODE ANN. § 47-18-101 *et seq.* ("TCPA"); all recoverable costs, expenses and attorney's fees; and pre- and post-judgment interest on all sums awarded.

3. In the First Amended Complaint, Plaintiffs allege that between 1995 and 2000, Aetna improperly refused insurance coverage to Welshans.

4. In the First Amended Complaint, Plaintiffs allege that they are both residents of Tennessee.

5. Aetna is incorporated under the laws of the state of Connecticut, with its principal place of business in Hartford, Connecticut, and is authorized to engage in the insurance business in Tennessee. (See Declaration of Arthur A. Palmunen, attached hereto as Exhibit 2, ¶ 3; see also First Am. Compl., ¶ 2). Thus, for purposes of jurisdiction, Aetna is a citizen of the state of Connecticut. (See 28 U.S.C. § 1332(c)(l)).

6. Plaintiffs' First Amended Complaint also alleges that Plaintiffs seek a judgment in this matter in the amount of $74,999.00, exclusive of interest, costs and attorney's fees under each of their claims. Plaintiffs also claim, however, that the actual damages sustained by Plaintiffs is $74,999.00. (See First Am. Compl., ¶¶ 57, 62 and 73). Furthermore, Tennessee Rule of Civil Procedure 54.03, the counterpart to Federal Rule of Civil Procedure 54(c), states:

> Except as to a party against whom a judgment is entered by default, every final judgment shall grant the relief to which the party in whose favor it is rendered is entitled, even if the party has not demanded such relief in the party's pleadings . . . .

TENN. R. CIV. P. 54.03. Pursuant to this Rule, a plaintiff may seek and recover damages exceeding the amount prayed for in the complaint. *See Rogers* v. *Wal-Mart Stores, Inc.*, 230 F.3d 868, 871 (6th Cir. 2000). Therefore, Plaintiff's allegations notwithstanding, Aetna is entitled to remove this case

if it can show that it is more likely than not that Plaintiffs' claims meet the amount in controversy requirement. *See Rogers,* 230 F.3d at 871-72 (permitting removal despite the fact that the plaintiff stipulated her damages would not exceed the jurisdictional amount).

7. The following analysis is made to demonstrate the amount in controversy in this case. By making this analysis, Aetna makes no admission that Plaintiffs are entitled to these damages or any other damages. Rather, this analysis is made solely to demonstrate that the First Amended Complaint satisfies the standard for removal in the Sixth Circuit. *See Gafford v. General Elec. Co.*, 197 F.2d 150, 158-59 (6th Cir. 1993) (noting that where complaint seeks to recover an unspecified amount of damages, defendant must show that the complaint "more likely than not" seeks an amount in excess of the diversity jurisdictional requirement); *Rogers,* 230 F.3d at 871 (noting that removal is proper if defendant can show the complaint more likely than not satisfies the jurisdictional requirements).

(a) Plaintiffs expressly allege as a result of Aetna's conduct - including alleged breaches of express and implied terms of the Plan, misrepresentations and unfair actions in denying claims, and refusal to pay claims - that Plaintiffs have suffered actual damages in the amount of $74,999.00. (First Am. Compl., ¶ 57, 62 and 73).

(b) Pursuant to TENN. CODE ANN. § 56-7-105, Plaintiffs claim they are entitled to recover

"a 25% penalty on all sums recovered, along with interest, attorneys fees, and costs." (First Am. Compl. ¶ 74). Based upon their alleged actual damages of $74,999.00 (First Am. Compl. ¶ 73). this penalty would be an additional $18,749.75. Therefore, Plaintiffs assert they are entitled to $93.748.75 under this claim.

(c) Pursuant to TENN. CODE ANN. § 47-18-109, Plaintiffs claim they are entitled "to recover treble the amount of their actual damages." (First Am. Compl. ¶ 64). Based upon their alleged actual damages of $74,999.00 (First Am. Compl. ¶ 62), this trebled amount would be $224,997.00.

(d) Alternatively, Exhibit 4 to Plaintiffs' First Amended Complaint - which purportedly itemizes the disputed claims upon which Plaintiffs base their lawsuit - alleges that Aetna owes Plaintiffs $28,115.13. (First Am. Compl.. Ex. 4). It appears that this list may not be exhaustive, as Plaintiffs also allege that they believe there may be claims in addition to the ones listed in Exhibit 4. (First Am. Compl. ¶ 41). Even assuming this figure of $28,115.13 represents Plaintiffs' actual damages, pursuant to the TCPA, Plaintiffs claim they are entitled to recover treble the amount. (First Am. Compl. ¶ 64). This trebled amount would be $84,345.39.

(e) Plaintiffs also request attorneys fees under the provisions of TENN. CODE ANN. § 47-18-109 and 56-7-105.

(f) Thus, Plaintiffs are asking for an award of actual damages in the mount of $93,748.75 - $74,999.00 in actual damages plus a penalty of $18,749.75 - plus attorney's fees under TENN. CODE ANN. § 56-7-105; and an award of damages in an amount of $224,997.00 - treble the amount of claimed actual damages of $74,999.00 - plus attorney's fees under TENN. CODE ANN. § 47-18-109. Alternatively, pursuant to their itemization of alleged claims, Plaintiffs are asking for an award of damages in the amount of $84,345.39 - treble the amount of claimed damages of $28,115.13 - plus attorney's fees. Under any of these analyses, Plaintiffs are clearly seeking damages in excess of $75,000.00.

(g) Further, Plaintiffs admit that the claims asserted in this present lawsuit are the same claims asserted against Aetna in *Peggy Welsham Williamson, et al. v. Aetna Life Insurance Co.,* Case Nos. 3:99-0061 and 3:99-0062 (consolidated under Case No. 3:99-0061), previously filed in the United States District Court for the Middle District of Tennessee and voluntarily dismissed on September 22, 2003. (First An. Compl. ¶ 4). A copy of the Amended Complaint filed by Plaintiffs in the previous lawsuit is attached hereto as Exhibit 3. Plaintiffs alleged in the

previous lawsuit, which admittedly asserted the same claims against the same Defendant, that the amount in controversy exceeds $75,000.00. (See Ex. 3, ¶¶ 2, 24, 25 and ¶¶ 2 and 4 of the Prayer for Relief therein).

8. From the foregoing, Aetna has demonstrated a good faith belief that Plaintiffs are more likely than not seeking damages in excess of $75,000.00.

9. This Court has original jurisdiction of this civil action pursuant to 28 U.S.C. § 1332 due to diversity of citizenship because Plaintiffs and Aetna are citizens of different states, and because the amount in controversy in this action on behalf of plaintiffs exceeds the sum or value of $75,000.00. exclusive of interest and costs.

10. This Notice of Removal is being filed within 30 days after Aetna received a copy of the Complaint and is therefore timely under 28 U.S.C. § 1446(b).

11. Venue is proper in this Court.

12. This action is removable to this Court pursuant to 28 U.S.C. § 1441(a).

13. Written notice of the filing of this Notice of Removal will be served on Plaintiffs and a Notice of Filing this Notice of Removal will be filed with the Circuit Court of Tennessee for the Thirtieth Judicial District at Memphis.

14. By filing this Notice of Removal, Aetna does not waive any defense to the Complaint or the First Amended Complaint.

WHEREFORE, Defendant Aetna removes this action from the Circuit Court of Tennessee for the Thirtieth Judicial District at Memphis to this Court.

Respectfully submitted,

FORD & HARRISON, LLP
6750 Poplar Avenue, Suite 600
Memphis, Tennessee 38138
Telephone: (901) 291-1500
Telefax: (901) 291-1501

By:/s/
Herbert E. Gerson Tenn. No. 8256
David P. Knox Tenn. No. 20192

Attorneys for Defendant, Aetna Life Insurance Co.

APPENDIX G

IN THE CIRCUIT COURT
OF SHELBY COUNTY, TENNESSEE
30TH JUDICIAL DISTRICT OF TENNESSEE

Case. No. CT-005301-04

[Filed September 15, 2004]

PEGGY WELSHANS WILLIAMSON	)
	)
and	)
	)
VANESSA WELSHANS,	)
	)
v.	)
	)
AETNA LIFE INSURANCE CO.,	)
	)

COMPLAINT

Come Peggy Welshans Williamson ("Williamson") and Vanessa Welshans ("Welshans"), by and through their undersigned lawyers, and for their claims against Aetna Life Insurance Company, ("Aetna"), allege and state as follows:

1. Welshans is a citizen of the state of Tennessee and is a resident of Memphis, Tennessee. Williamson

is a citizen of the state of Tennessee and is a resident of Jackson, Tennessee.

2. Aetna is a corporation authorized to engage in the business of insurance in Tennessee but neither its domiciliary state nor its principal place of business is located in Tennessee.

3. The court has jurisdiction over the parties and the subject matter, and venue in this district is proper.

4. The claims asserted herein are the same claims asserted in *Peggy Wellshans Williamson, et al., v. Aetna Life Insurance Co.*, Case Nos. 3:99-0061 & 3:99-0062 (Consolidated) (M.D. Tenn.), which were dismissed without prejudice on September 22, 2003.

5. Welshans is the daughter of Williamson.

6. Williamson is a retired employee of General Agencies of the United Methodist Church ("General Agencies").

7. General Agencies provides for health insurance coverage of its employees through its health plan (the "Plan"), and Williamson is an insured under the Plan. The Plan was written by the General Agencies.

8. The Plan provided for coverage of dependents of persons who are insured. The Plan also provides for continued coverage of dependents who reach the maximum age for dependents if such dependent is handicapped as defined by the Plan as follows:

he or she is not able to earn his or her own living because of mental retardation of a physical handicap which started prior to the date he or she reaches the maximum age for dependents; and

he or she chiefly depends on you or another care provider for support.

9. Even though Welshans has passed the maximum age for a dependent, she has at all times since 1983 been "handicapped dependent" as defined by the Plan. Neither the General Agencies, administrators before Aetna, nor administrators after Aetna have questioned whether Welshans was or is "handicapped dependent" as defined by the plan.

10. Prior to 1995, the Plan was administered by Cigna. Aetna administered the group health insurance plan for the General Agencies from January 1, 1995 through December 31, 2000. Cigna has administered the Plan since that time.

11. In 1995 Aetna in fact found that Welshans was handicapped and treated Welshans as a dependent and covered her medical expenses which were payable under the Plan which covers Williamson.

12. Williamson and the General Agencies at all relevant times paid all premiums due for coverage of Welshans under the Plan, and there has been no return of that premium or even its tender by defendant.

13. Welshans was born March 30, 1961, and is currently 43 years of age. Although Welshans passed the maximum age for a dependent child, she has been handicapped within the definition set out in paragraph 12 of this complaint since May 15, 1983. Welshans is entitled under the terms and provisions of the Plan to be covered under the terms of the Plan.

14. Welshans was severely injured in a car wreck on or about May 15, 1983. Welshans was 22 at the time and suffered numerous broken bones, including both legs, her pelvis, and her back. Her left knee was also severely injured and one leg was left shorter than the other. Between 1983 and 1996, she underwent approximately 7 surgeries on her knee, and at all times since 1983 has suffered constant pain and discomfort. Her condition has not improved, she has been determined by Social Security to be disabled, and she has chiefly relied on her mother, Williamson, for her support at all times since 1983.

15. Welshans was determined to be disabled by Social Security in 1983 or 1984 and has drawn Social Security disability benefits since that time.

16. Since 1983 through present, Welshans has not able to earn her own living because of her physical disability.

17. At all times since 1983 through present, Welshans has chiefly depended on Williamson for support.

18. Welshans turned 25 on March 31, 1986, and was considered "handicapped dependent" under the terms of the Plan at that time.

19. Welshans was considered "'handicapped dependent" under the Plan at all times from March 30, 1986, when she turned 25 until Aetna, after taking over as administrator of the Plan from Cigna in 1995, initially denied her coverage in 1996.

20. Until 1995, Cigna administered the Plan.

21. Aetna began administering the Plan for the General Agencies of the United Methodist Church, which covered Ms. Williamson, on or about January 1, 1995.

22. There was never any dispute or question that Welshans was "handicapped dependent" prior to Aetna taking over as administrator of the GUAMC health insurance plan in 1995. After Aetna took over as administrator, Aetna covered Welshans in 1995.

23. The language of the Plan was in effect prior to Welshans becoming disabled in 1983 and has never changed with regard to the definition of "handicapped dependent."

24. Since she has reached the maximum age for a dependent child in 1986, Welshans has over the years presented the very same medical evidence to the carder for the Plan which proved that she was entitled to be continued as a dependent child. Aetna received the very same medical proof in 1995 from Dr. Thomas

J. Limbird of Vanderbilt University, accepted same, and covered Welshans as a dependent.

25. In 1995, Welshans' doctor informed Aetna that:

> I believe that Ms. Welshans is incapable of working and maintaining full-time employment. Her physical examination has remained basically unchanged for years and I do not expect this to change appreciably in the future.

Exhibit 1.

In 1996, Welshans' doctor informed Aetna that:

> Ms. Welshans is unable to maintain employment for a number of reasons. Her left lower extremity problem makes her unable to stand, walk, climb steps or do any bending or squatting for a prolonged length of time. The asymmetry of her pelvis and resultant SI joint difficulties make it virtually impossible for her to sit for long periods of time. (She is capable of caring for herself and performing activities of daily living.)
>
> As to what is being done to rectify the current conditions, Ms. Welshans has somewhere in the neighborhood of seven major orthopedic operations on her left knee in an attempt to regain function as much as possible.

Exhibit 2.

26. Nevertheless, in 1996, Aetna's Cost Containment Unit effectively terminated Welshans'

coverage without any notice to Welshans by somehow concluding that Welshans' "limitations do not seem to be of severity to preclude full time employment" and "accommodations to deal with this degree of impairment are made every day... Deny req for incap child status." Aetna had absolutely no medical evidence in its file to support such a determination and disregarded the unrefuted medical evidence in its fide, included the determination made by Aetna's own doctor in making the determination. Welshans initially filed suit in 1996, and the result was Aetna provided coverage for that year.

27. Upon information and belief, representatives of the General Agencies also informed Aetna on several occasions between January 1, 1995, and December 31, 2000, that the General Agencies also considered Welshans to be "handicapped dependent" under the language of the Plan.

28. Nevertheless, beginning in late 1995 and continuing into 1996, Aetna began denying coverage for Welshans contending, contrary to the rest of the world, that Welshans was not a "handicapped dependent" under the definition of the Plan.

29. In doing so, Aetna, through nonlawyer employees of its "Cost Containment Unit," disregarded the language of the Plan and attempted to substitute a different definition, based on an Illinois state statute, than that found in the Plan. Those nonlawyer employees never sought legal advice in making that determination and attempted to unilaterally change the terms of the Plan solely for the purpose of denying coverage to Welshans and, possibly, the limited

number of other individuals covered by the Plan as "handicapped dependents."

30. Despite its denial of coverage for Welshans, Aetna also never obtained any medical evidence to dispute the conclusions Welshans' physician.

31. To the contrary, Aetna's own physician in reviewing the file appeared to corroborate Plaintiffs' contention when he wrote:

> It appears that she has significant disability that prevents her from getting a job. She is on SSI-Disability. I feel an independent ME would be beneficial - and if they agree with the findings, I feel her disability status is justified.
>
> Dr. Seth. Exhibit 3 at Bates 276.
>
> Exhibit 3 is a true and correct copy of a business record of Aetna.

32. The note reflected in Exhibit 3 was authored by Dr. Seth. Dr. Seth was a physician employed by, or contracting to provide services to, Aetna in order to review medical evidence when questions arose.

33. Accordingly, both Welshans' and Aetna's own physicians agreed that Welshans was disabled as of 1996.

34. Nevertheless, Aetna's Cost Containment Unit still refused to recognize Welshans as a "handicapped dependent" under the Plan, and began to offer new

reasons for denying coverage to Welshans. The purported reasons were a contrivance.

35. On August 16, 1996, Aetna's customer service personnel, under the supervision of .Ms. Spencer, upon receiving the letter from Dr. Limbird, noted that:

> Per my contact on 071396 we have reviewed other info from this Dr and determined Vanessa to be ineligible as an incapacitated child based on that info.

36. Aetna has never obtained any medical evidence to dispute or contradict Dr. Limbird's conclusions and statements. At no time since 1995 did Aetna ever obtain any medical evidence to suggest that Welshans' condition has improved appreciably or that she could earn her own living or obtain full time employment.

37. In 1996, Aetna terminated Welshans' coverage. In 1998, Aetna agreed to pay all of Welshans' claims back through 1996. Aetna further made a determination that Welshans was covered a covered dependent and agreed to treat her as such.

38. Nevertheless, in late 1998, shortly after agreeing that Welshans should be covered as a handicapped dependent as part of an agreement whereby Plaintiffs voluntarily dismissed without prejudice their first lawsuit against Aetna, Aetna again ignored the information already on record and requested that Welshans" status be verified. Aetna then again denied coverage for Welshans, again claiming that Welshans did not qualify as "handicapped dependent."

39. Aetna also continued to refuse to pay Welshans' claims, now contending that the claims were not covered under the Plan. Aetna's contention was a contrivance, as evidenced by the fact that Aetna was also again requesting evidence for the purpose of again disputing Welshans' status as a "handicapped dependent," and also in denying many of the claims by contending that Welshans was not a handicapped dependent under the Plan.

40. Aetna's requests for proof of Welshans' continued status as "handicapped dependent" were not made in good faith and were unreasonable in light of the uncontroverted medical evidence in Aetna's file that Welshans was disabled and her condition was not going to improve.

41. Attached as Exhibit 4 is a true and correct list of claims for medical expenses incurred by Welshans, submitted to Aetna, and wrongly denied by Aetna. It is believed that there are others.

42. Plaintiffs were required to pay the medical providers for each of the claims listed in Exhibit 4, for which Aetna wrongly denied coverage. The payments by plaintiffs were made jointly, with Williams depositing said funds into Welshans' account and Welshans making payment to the providers. At all relevant times Welshans chiefly depended on Williamson for support. Accordingly, plaintiffs bring there claims against Aetna jointly.

43. For each claim listed in Exhibit 4, Aetna failed and refused topay said claim within 60 days of receiving notice.

44. For each claim listed in Exhibit 4, Aetna failed and refused to investigate said claim in good faith.

45. At all times between 1995 and 2000, the medical proof that had been acceptable for years still existed, and Aetna continued to accept premiums paid by Williamson on behalf of Welshans under the Plan.

46. For completely arbitrary and capricious reasons and in violation of the written terms of the Plan, Aetna has refused to treat Welshans as a dependent even though she met the definition required to keep her as a dependent of Williamson and even though premiums for her coverage were paid to and accepted by Aetna.

47. Plaintiffs incurred covered expenses under the Plan. Aetna, although keeping the premium paid for Welshans' benefit, failed to pay the medical expenses of Welshans despite proper proof of same.

48. Williamson and Welshans are third party beneficiaries of the Plan and Aetna's agreement with UMCOM to administer the Plan between 1995 and 2000. As a beneficiary of the agreement between Williamson and UMCOM, Welshans is entitled to the benefits of the Plan.

49. With respect to the claims, Aetna has offered a variety of numerous reasons for denying them, creating a new reason every time it was presented with the evidence it requested. Initially, Aetna denied that Welshans was a "handicapped dependent" under the Plan, first claiming that Welshans was not handicapped, then claiming that Welshans was not a

dependent then claiming that claims were not timely submitted, then claiming that the claims had already been considered, then claiming that the claims were not medically necessary, then claiming that the claims were not covered, and finally claiming again that Welshans was not "handicapped dependent."

50. Beginning in 1996, after Welshans condition and status as a handicapped dependent had been unchanged for 13 years, Aetna denied coverage for Welshans every year despite the uncontroverted medical evidence submitted by Welshans. After apparently recognizing the absurdity of challenging Welshans' condition, Aetna then attempted to redefine "handicapped dependent" by using its own varying interpretations of the term and adding elements of the definition not found in the Plan. Aetna refused to pay attention to the medical evidence or the plain language in the Plan defining "'handicapped dependent." Even with the portions of the claims that Aetna did pay, it failed to pay the claims within sixty (60) days.

COUNT I

BREACH OF CONTRACT

51. Plaintiffs incorporate the foregoing paragraphs by reference.

52. Aetna breached the terms of the Plan by terminating Welshans' coverage on numerous occasions, unreasonably continuing to request verification of Welshans' condition and status, continuously reinterpreting the definition of "handicapped dependent" in a manner inconsistent

with the Plan, continuously refusing to pay claims between 1995 and 2000, failing to investigate the claims in good faith, and failing to pay the medical claims in a timely manner within 60 days of receiving notice of the claims.

53. In light of the absence of any change in the Plan's defmition of "handicapped dependent," the uncontroverted medical information already in Aetna's file (including Aetna's own physician's review), the on-going dispute between the parties from 1996 through present, Aetna's agreement in 1998 to cover Welshans, the fact that the information in Aetna's file indicated that Welshans' condition had not improved in years and was unlikely to do so in the future, Aetna's continued requests for additional information were wholly unreasonable and in bad faith.

54. One does not need to speculate about Aetna's motivation. One need only look at Aetna's business records, the lack of any specificity in Aetna's denials other than its effort to deny coverage to Welshans, and the chameleon-like changes in its explanations since 1995, which continue to date, in order to draw the conclusion that Aetna acted improperly and in bad faith.

55. Aetna further breached the covenants of good faith and fair dealing.

56. As a result of Aetna's breaches of the express and implied terms of the Plan, plaintiffs suffered damages in an amount to be determined at trial, but which is less than $75,000.

TENNESSEE CONSUMER PROTECTION ACT TENN. CODE ANN. § 47-18-104

57. Plaintiffs incorporate the foregoing paragraphs by reference.

58. In the course of handling plaintiffs' claims, Aetna's conflicting, sequential reasons for denials, refusal to apply the plain language of the Plan, disregard for uncontroverted medical evidence in its files, continuously shifting explanations for why claims were not paid, refusal to pay the claims listed in Exhibit 4, and ultimate return to its original determination that Welshans was somehow not "handicapped dependent" as that term is defined in the Plan, were deceptive insured about terms of policy and otherwise unfair to plaintiffs, and were intended by Aetna to be deceptive and unfair to plaintiffs.

59. Aetna repeatedly ignored and misrepresented the terms of the Plan in connection with its denials of coverage for Wetshans. Aetna further repeatedly misrepresented the reasons for its denials of the Welshans claims.

60. After being sued and confronted with uncontroverted evidence of Welshans' eligibility as a handicapped dependent under the plan, Aetna began denying claims without any apparent investigation or supporting documentation and falsely stating that Welshans' claims were not payable under the Plan anyway. Such statements were false and know by Aetna to be false.

61. As a result of Aetna's misrepresentations and unfair actions in denying the claims, plaintiffs suffered damages in an amount to be determined at trial, but which is less than $75,000.

62. Aetna's conduct in denying coverage, and then later failing to pay the claims or even investigate them in good faith, was unfair and deceptive within the meaning of the Tennessee Consumer Protection Act. Aetna's violation of the Tennessee Consumer Protection Act was willful and knowing.

63. Pursuant to Tenn. Code Ann. § 47-18-109, plaintiffs are entitled to recover treble the amount of their actual damages. Plaintiffs are further entitled to recover pre-judgment and post-judgment interest on all sums awarded, and their costs, expenses, and attorneys' fees.

BAD FAITH

TENN. CODE ANN. § 56-7-105

64. Plaintiffs incorporate the foregoing paragraphs by reference.

65. Pursuant to Tenn. Code Ann. § 56-7-105, an insurance company in Tennessee must pay a claim within sixty (60) days unless it has a good faith basis for disputing the claim.

66. Aetna had no good faith basis for disputing any of the claims listed in Exhibit 4.

67. Each of the claims was submitted to Aetna more than sixty (days) prior to the filing of this lawsuit.

68. Aetna has failed to pay any of the claims and has no good faith reason for refusing to pay the claims.

69. Aetna knowingly disregarded the evidence in its file and the language of the Plan during the entire time it was the administrator of the Plan.

70. Each of the claims listed in Exhibit 4 was due and payable when submitted to Aetna. In addition to the submission of the claims, plaintiffs have made additional formal demands for payment of each claim more than 60 days prior to the filing of this suit.

71. Aetna's refusal to pay was not in good faith.

72. As a result of Aetna's actions violating the Tennessee Consumer Protection Act, plaintiffs suffered actual and other damages in an amount to be proven at trial, but which is less than $75,000.

73. Pursuant to Tenn. Code Ann. § 56-7-105, plaintiffs are entitled to recover a 25 percent penalty on all sums recovered, along with interest, attorneys fees, and costs.

JURY TRIAL

74. Plaintiffs demand a trial by jury on all issues of fact triable to a jury.

THEREFORE, plaintiffs pray:

a) For judgment three times the amount of their actual damages (including pre-judgment interest), which are to be determined at trial, or, alternatively, their actual damages (including pre-judgment interest) plus the 25 percent penalty provided by Tenn. Code Ann. § 56-7-105;

b) For their costs, expenses, and reasonable attorneys fees;

c) For post-judgment interest on all sums awarded at the maximum rate of interest permitted by law; and,

d) All other just and proper relief to which they may be entitled.

Respectfully Submitted,
PEGGY WELSHANS WILLIAMSON
VANESSA WELSHANS

By:/s/
Kent J. Rubens (Ark. 71067)

/s/
Lawrence W. Jackson (Ark. 92194)

/s/

Gary Shaun Hair, Jr. (Tenn. 023279)
Lawyers for Plaintiff
Rieves, Rubens & Mayton
Post Office Box 1359
West Memphis, Arkansas 72303
(870) 735-3420

And

/s/

Kathleen G. Morris
Attorney at Law
P.O. Box 128091
Nashville, TN 37212
(615) 320-8899

APPENDIX H

IN THE CIRCUIT COURT OF SHELBY COUNTY, TENNESSEE 30th JUDICIAL DISTRICT OF TENNESSEE

No. CT 005301-04 (Div. 4)

[Filed September 20, 2004]

PEGGY WELSHANS WILLIAMSON AND VANESSA WELSHANS, Plaintiffs,	)
v.	)
AETNA LIFE INSURANCE CO., Defendant.	)

Come Peggy Welshans Williamson ("Williamson") and Vanessa Welshans ("Welshans"), by and through their undersigned lawyers, and for their first amended complaint against Aetna Life Insurance Company, ("Aetna"), allege and state as follows:

1. Welshans is a citizen of the state of Tennessee and is a resident of Memphis, Tennessee. Williamson is a citizen of the state of Tennessee and is a resident of Jackson, Tennessee.

2. Aetna is a corporation authorized to engage in the business of insurance in Tennessee but neither its domiciliary state nor its principal place of business is located in Tennessee.

3. The court has jurisdiction over the parties and the subject matter, and venue in this district is proper.

4. The claims asserted herein are the same claims asserted in *Peggy Wellshans Williamson, et al., v. Aetna Life Insurance Co.,* Case Nos. 3:99-0061 & 3:99-0062 (Consolidated) (M.D. Tenn.), which were dismissed without prejudice on September 22, 2003.

5. Welshans is the daughter of Williamson.

6. Williamson is a retired employee of General Agencies of the United Methodist Church ("General Agencies").

7. General Agencies provides for health insurance coverage of its employees through its health plan (the "Plan"), and Williamson is an insured under the Plan. The Plan was written by the General Agencies.

8. The Plan provided for coverage of dependents of persons who are insured. The Plan also provides for continued coverage of dependents who reach the maximum age for dependents if such dependent is handicapped as defined by the Plan as follows:

> he or she is not able to earn his or her own living because of mental retardation of a physical handicap which started prior to the

date he or she reaches the maximum age for dependents; and

he or she chiefly depends on you or another care provider for support.

9. Even though Welshans has passed the maximum age for a dependent, she has at all times since 1983 been "handicapped dependent" as defined by the Plan. Neither the General Agencies, administrators before Aetna, nor administrators after Aetna have questioned whether Welshans was or is "'handicapped dependent" as defined by the plan.

10. Prior to 1995, the Plan was administered by Cigna. Aetna administered the group health insurance plan for the General Agencies from January 1, 1995 through December 31, 2000. Cigna has administered the Plan since that time.

11. In 1995 Aetna in fact found that Welshans was handicapped and treated Welshans as a dependent and covered her medical expenses which were payable under the Plan which covers Williamson.

12. Williamson and the General Agencies at all relevant times paid all premiums due for coverage of Welshans under the Plan, and there has been no return of that premium or even its tender by defendant.

13. Welshans was born March 30, 1961, and is currently 43 years of age. Although Welshans passed the maximum age for a dependent child, she has been handicapped within the definition set out in paragraph

12 of this complaint since May 15, 1983. Welshans is entitled under the terms and provisions of the Plan to be covered under the terms of the Plan.

14. Welshans was severely injured in a car wreck on or about May 15, 1983. Welshans was 22 at the time and suffered numerous broken bones, including both legs, her pelvis, and her back. Her left knee was also severely injured and one leg was left shorter than the other. Between 1983 and 1996, she underwent approximately 7 surgeries on her knee, and at all times since 1983 has suffered constant pain and discomfort. Her condition has not improved, she has been determined by Social Security to be disabled, and she has chiefly relied on her mother, Williamson, for her support at all times since 1983.

15. Welshans was determined to be disabled by Social Security in 1983 or 1984 and has drawn Social Security disability benefits since that time.

16. Since 1983 through present, Welshans has not able to earn her own living because of her physical disability.

17. At all times since 1983 through present, Welshans has chiefly depended on Williamson for support.

18. Welshans turned 25 on March 31, 1986, and was considered "handicapped dependent" under the terms of the Plan at that time.

19. Welshans was considered "handicapped dependent" under the Plan at all times from March 30,

1986, when she turned 25 until Aetna, after taking over as administrator of the Plan from Cigna in 1995, initially denied her coverage in 1996.

20. Until 1995, Cigna administered the Plan.

21. Aetna began administering the Plan for the General Agencies of the United Methodist Church, which covered Ms. Williamson, on or about January 1, 1995.

22. There was never any dispute or question that Welshans was "handicapped dependent" prior to Aetna taking over as administrator of the GUAMC health insurance plan in 1995. After Aetna took over as administrator, Aetna covered Welshans in 1995.

23. The language of the Plan was in effect prior to Welshans becoming disabled in 1983 and has never changed with regard to the definition of "handicapped dependent."

24. Since she has reached the maximum age for a dependent child in 1986, Welshans has over the years presented the very same medical evidence to the carrier for the Plan which proved that she was entitled to be continued as a dependent child. Aetna received the very same medical proof in 1995 from Dr. Thomas J. Limbird of Vanderbilt University, accepted same, and covered Welshans as a dependent.

25. In 1995, Welshans' doctor informed Aetna that:

> I believe that Ms. Welshans is incapable of working and maintaining full-time employment.

> Her physical examination has remained basically unchanged for years and I do not expect this to change appreciably in the future.

Exhibit 1.

> In 1996, Welshans' doctor informed Aetna that:
>
> Ms. Welshans is unable to maintain employment for a number of reasons. Her left lower extremity problem makes her unable to stand, walk, climb steps or do any bending or squatting for a prolonged length of time. The asymmetry of her pelvis and resultant SI joint difficulties make it virtually impossible for her to sit for long periods of time. (She is capable of caring for herself and performing activities of daily living.)
>
> As to what is being done to rectify the current conditions, Ms. Welshans has somewhere in the neighborhood of seven major orthopedic operations on her left knee in an attempt to regain function as much as possible.

Exhibit 2.

26. Nevertheless, in 1996, Aetna's Cost Containment Unit effectively terminated Welshans' coverage without any notice to Welshans by somehow concluding that Welshans' "limitations do not seem to be of severity to preclude full time employment" and "accommodations to deal with this degree of impairment are made every day... Deny req for incap child status." Aetna had absolutely no medical

evidence in its file to support such a determination and disregarded the unrefuted medical evidence in its file, included the determination made by Aetna's own doctor in making the determination. Welshans initially filed suit in 1996, and the result was Aetna provided coverage for that year.

27. Upon information and belief, representatives of the General Agencies also informed Aetna on several occasions between January 1, 1995, and December 31, 2000, that the General Agencies also considered Welshans to be "handicapped dependent" under the language of the Plan.

28. Nevertheless, beginning in late 1995 and continuing into 1996, Aetna began denying coverage for Welshans contending, contrary to the rest of the world, that Welshans was not a "handicapped dependent" under the definition of the Plan.

29. In doing so, Aetna, through nonlawyer employees of its "Cost Containment Unit," disregarded the language of the Plan and attempted to substitute a different definition, based on an Illinois state statute, than that found in the Plan. Those nonlawyer employees never sought legal advice in making that determination and attempted to unilaterally change the terms of the Plan solely for the purpose of denying coverage to Welshans and, possibly, the limited number of other individuals covered by the Plan as "handicapped dependents."

30. Despite its denial of coverage for Welshans, Aetna also never obtained any medical evidence to dispute the conclusions Welshans' physician.

31. To the contrary, Aetna's own physician in reviewing the file appeared to corroborate Plaintiffs' contention when he wrote:

> It appears that she has significant disability that prevents her from getting a job. She is on SSI-Disability. I feel an independent IME would be beneficial — and if they agree with the findings, I feel her disability status is justified.

Dr. Seth. Exhibit 3 at Bates 276.

Exhibit 3 is a true and correct copy of a business record of Aetna.

32. The note reflected in Exhibit 3 was authored by Dr. Seth. Dr. Seth was a physician employed by, or contracting to provide services to, Aetna in order to review medical evidence when questions arose.

33. Accordingly, both Welshans' and Aetna's own physicians agreed that Welshans was disabled as of 1996.

34. Nevertheless, Aetna's Cost Containment Unit still refused to recognize Welshans as a "handicapped dependent" under the Plan, and began to offer new reasons for denying coverage to Welshans. The purported reasons were a contrivance.

35. On August 16, 1996, Aetna's customer service personnel, under the supervision of Ms. Spencer, upon receiving the letter from Dr. Limbird, noted that:

> Per my contact on 071396 we have reviewed other info from this Dr and determined Vanessa to be ineligible as an incapacitated child based on that info.

36. Aetna has never obtained any medical evidence to dispute or contradict Dr. Limbird's conclusions and statements. At no time since 1995 did Aetna ever obtain any medical evidence to suggest that Welshans' condition has improved appreciably or that she could earn her own living or obtain full time employment.

37. In 1996, Aetna terminated Welshans' coverage. In 1998, Aetna agreed to pay all of Welshans' claims back through 1996. Aetna further made a determination that Welshans was covered a covered dependent and agreed to treat her as such.

38. Nevertheless, in late 1998, shortly after agreeing that Welshans should be covered as a handicapped dependent as part of an agreement whereby Plaintiffs voluntarily dismissed without prejudice their first lawsuit against Aetna, Aetna again ignored the information already on record and requested that Welshans' status be verified. Aetna then again denied coverage for Welshans, again claiming that Welshans did not qualify as "handicapped dependent."

39. Aetna also continued to refuse to pay Welshans' claims, now contending that the claims were not covered under the Plan. Aetna's contention was a contrivance, as evidenced by the fact that Aetna was also again requesting evidence for the purpose of again disputing Welshans' status as a "'handicapped

dependent," and also in denying many of the claims by contending that Welshans was not a handicapped dependent under the Plan.

40. Aetna's requests for proof of Welshans' continued status as "handicapped dependent" were not-made in good faith and were unreasonable in light of the uncontroverted medical evidence in Aetna's file that Welshans was disabled and her condition was not going to improve.

41. Attached as Exhibit 4 is a true and correct list of claims for medical expenses incurred by Welshans, submitted to Aetna, and wrongly denied by Aetna. It is believed that there are others.

42. Plaintiffs were required to pay the medical providers for each of the claims listed in Exhibit 4, for which Aetna wrongly denied coverage. The payments by plaintiffs were made jointly, with Williams depositing said funds into Welshans' account and Welshans making payment to the providers. At all relevant times Welshans chiefly depended on Williamson for support. Accordingly, plaintiffs bring there claims against Aetna jointly.

43. For each claim listed in Exhibit 4, Aetna failed and refused to pay said claim within 60 days of receiving notice.

44. For each claim listed in Exhibit 4, Aetna failed and refused to investigate said claim in good faith.

45. At all times between 1995 and 2000, the medical proof that had been acceptable for years still

existed, and Aetna continued to accept premiums paid by Williamson on behalf of Welshans under the Plan.

46. For completely arbitrary and capricious reasons and in violation of the written terms of the Plan, Aetna has refused to treat Welshans as a dependent even though she met the definition required to keep her as a dependent of Williamson and even though premiums for her coverage were paid to and accepted by Aetna.

47. Plaintiffs incurred covered expenses under the Plan. Aetna, although keeping the premium paid for Welshans' benefit, failed to pay the medical expenses of Welshans despite proper proof of same.

48. Williamson and Welshans are third party beneficiaries of the Plan and Aetna's agreement with UMCOM to administer the Plan between 1995 and 2000. As a beneficiary of the agreement between Williamson and UMCOM, Welshans is entitled to the benefits of the Plan.

49. With respect to the claims, Aetna has offered a variety of numerous reasons for denying them, creating a new reason every time it was presented with the evidence it requested. Initially, Aetna denied that Welshans was a "handicapped dependent" under the Plan, first claiming that Welshans was not handicapped, then claiming that Welshans was not a dependent, then claiming that claims were not timely submitted, then claiming that the claims had already been considered, then claiming that the claims were not medically necessary, then claiming that the claims were not covered, and finally claiming again that Welshans was not "handicapped dependent."

50. Beginning in 1996, after Welshans condition and status as a handicapped dependent had been unchanged for 13 years, Aetna denied coverage for Welshans every year despite the uncontroverted medical evidence submitted by Welshans. After apparently recognizing the absurdity of challenging Welshans' condition, Aetna then attempted to redefine "handicapped dependent" by using its own varying interpretations of the term and adding elements of the definition not found in the Plan. Aetna refused to pay attention to the medical evidence or the plain language in the Plan defining "handicapped dependent." Even with the portions of the claims that Aetna did pay, it failed to pay the claims within sixty (60) days.

51. Plaintiff seeks judgment in this matter in the amount of $74,999, exclusive of interest, costs, and attorneys fees under each of her claims.

COUNT I
BREACH OF CONTRACT

52. Plaintiffs incorporate the foregoing paragraphs by reference.

53. Aetna breached the terms of the Plan by terminating Welshans' coverage on numerous occasions, unreasonably continuing to request verification of Welshans' condition and status, continuously reinterpreting the definition of "handicapped dependent" in a manner inconsistent with the Plan, continuously refusing to pay claims between 1995 and 2000, failing to investigate the claims in good faith, and failing to pay the medical

claims in a timely manner within 60 days of receiving notice of the claims.

54. In light of the absence of any change in the Plan's definition of "handicapped dependent," the uncontroverted medical information already in Aetna's file (including Aetna's own physician's review), the on-going dispute between the parties from 1996 through present, Aetna's agreement in 1998 to cover Welshans, the fact that the information in Aetna's file indicated that Welshans' condition had not improved in years and was unlikely to do so in the future, Aetna's continued requests for additional information were wholly unreasonable and in bad faith.

55. One does not need to speculate about Aetna's motivation. One need only look at Aetna's business records, the lack of any specificity in Aetna's denials other than its effort to deny coverage to Welshans, and the chameleon-like changes in its explanations since 1995, which continue to date, in order to draw the conclusion that Aetna acted improperly and in bad faith.

56. Aetna further breached the covenants of good faith and fair dealing.

57. As a result of Aetna's breaches of the express and implied terms of the Plan, plaintiffs suffered damages in the amount of $74,999.

TENNESSEE CONSUMER PROTECTION ACT TENN. CODE ANN. § 47-18-104

58. Plaintiffs incorporate the foregoing paragraphs by reference.

59. In the course of handling plaintiffs' claims, Aetna's conflicting, sequential reasons for denials, refusal to apply the plain language of the Plan, disregard for uncontroverted medical evidence in its files, continuously shifting explanations for why claims were not paid, refusal to pay the claims listed in Exhibit 4, and ultimate return to its original determination that Welshans was somehow not "handicapped dependent" as that term is defined in the Plan, were deceptive insured about terms of policy and otherwise unfair to plaintiffs, and were intended by Aetna to be deceptive and unfair to plaintiffs.

60. Aetna repeatedly ignored and misrepresented the terms of the Plan in connection with its denials of coverage for Welshans. Aetna further repeatedly misrepresented the reasons for its denials of the Welshans claims.

61. After being sued and confronted with uncontroverted evidence of Welshans' eligibility as a handicapped dependent under the plan, Aetna began denying claims without any apparent investigation or supporting documentation and falsely stating that Welshans' claims were not payable under the Plan anyway. Such statements were false and know by Aetna to be false.

62. As a result of Aetna's misrepresentations and unfair actions in denying the claims, plaintiffs suffered damages in the amount of $74,999.

63. Aetna's conduct in denying coverage, and then later failing to pay the claims or even investigate them in good faith, was unfair and deceptive within the meaning of the Tennessee Consumer Protection Act. Aetna's violation of the Tennessee Consumer Protection Act was willful and knowing.

64. Pursuant to Tenn. Code Ann. § 47-18-109, plaintiffs are entitled to recover treble the amount of their actual damages. Plaintiffs are further entitled to recover pre-judgment and post-judgment interest on all sums awarded, and their costs, expenses, and attorneys' fees.

BAD FAITH
TENN. CODE ANN. § 56-7-105

65. Plaintiffs incorporate the foregoing paragraphs by reference.

66. Pursuant to Tenn. Code Ann. § 56-7-105, an insurance company in Tennessee must pay a claim within sixty (60) days unless it has a good faith basis for disputing the claim.

67. Aetna had no good faith basis for disputing any of the claims listed in Exhibit 4.

68. Each of the claims was submitted to Aetna more than sixty (days) prior to the filing of this lawsuit.

69. Aetna has failed to pay any of the claims and has no good faith reason for refusing to pay the claims.

70. Aetna knowingly disregarded the evidence in its file and the language of the Plan during the entire time it was the administrator of the Plan.

71. Each of the claims listed in Exhibit 4 was due and payable when submitted to Aetna. In addition to the submission of the claims, plaintiffs have made additional formal demands for payment of each claim more than 60 days prior to the filing of this suit.

72. Aetna's refusal to pay was not in good faith.

73. As a result of Aetna's actions violating the Tennessee Consumer Protection Act, plaintiffs suffered actual and other damages in the amount of $74,999.

74. Pursuant to Tenn. Code Ann. § 56-7-105, plaintiffs are entitled to recover a 25 percent penalty on all sums recovered, along with interest, attorneys fees, and costs.

JURY TRIAL

75. Plaintiffs demand a trial by jury on all issues of fact triable to a jury.

THEREFORE, plaintiffs pray:

a) For judgment three times the amount of their actual damages (including pre-judgment interest), which are to be determined at trial, or, alternatively, their actual damages (including pre-judgment interest)

plus the 25 percent penalty provided by Tenn. Code Ann. § 56-7-105, but limited to $74,999 exclusive of interest, costs, and attorneys fees;

b) For their costs, expenses, and reasonable attorneys fees;

c) For post-judgment interest on all sums awarded at the maximum rate of interest permitted by law; and,

d) All other just and proper relief to which they may be entitled.

Respectfiflly Submitted,
PEGGY WELSHANS WILLIAMSON
VANESSA WELSHANS

By: _____
Kent J. Rubens (Ark. 71067)

_____
Lawrence W. Jackson (Ark. 92194)

/s/ _____
Gary Shaun Hair Jr. (Tenn. 023279)
Lawyers for Plaintiff
Rieves, Rubens & Mayton
Post Office Box 1359
West Memphis, Arkansas 72303
(870) 735-3420

And

_____

Kathleen G. Morris
Attorney at Law
P.O. Box 128091
Nashville, TN 37212
(615) 320-8899

APPENDIX I

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF TENNESSEE WESTERN DIVISION

No. 04-2851 B

[Filed September 22, 2005]

PEGGY WELSHANS WILLLAMSON and VANESSA WELSHANS, Plaintiffs,	)
v.	)
AETNA LIFE INSURANCE CO., Defendant.	)

ORDER DENYING PLAINTIFFS' MOTION TO REMAND

This case involves a claim by Plaintiffs, Peggy Williamson and Vanessa Welshans, for health insurance benefits under an employee health plan provided to Williamson by her employer, General Agencies of the United Methodist Church ("General Agencies") and administered by Defendant Aetna Life

Insurance Co. ("Aetna").[13] Plaintiffs allege that Defendant Aetna wrongfully denied coverage for Williamson's daughter, Welshans, between 1995 and 2000, despite her continued qualification as a "handicapped dependent" under the plan. On January 22, 1999, Plaintiffs filed separate complaints in the United States District Court for the Middle District of Tennessee to recover damages for breach of contract, and violations of both the Tennessee Consumer Protection Act, Tenn. Code Ann. § 47-18-104, and the Tennessee "bad faith" statute, Tenn. Code Ann. § 56-7-105, as a result of Defendant's failure to pay Welshans"s medical claims.[14] In addition to a declaration that Welshans' and Williamson were entitled to coverage under the plan, Plaintiffs sought recovery of compensatory and punitive damages "in an amount as yet undetermined but in excess of $75,000;" the bad faith penalty of up to twenty-five percent of liability pursuant to Tenn. Code Ann. § 56-7-105; and recovery of treble damages in an undetermined amount in excess of $75,000 pursuant to Tenn. Code Ann. § 47-18-109(3). (Pl.'s Amend. Compl. M.D. Tenn. at 5.) On September 22, 2003, during a bench trial, Plaintiffs voluntarily non-suited their case and the court entered an order dismissing the action without prejudice.

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[13] Defendant Aetna administered General Agencies' group health plan from January 1, 1995 through December 31, 2000. (Amend. Compl. ¶ 10; Answer ¶ 10).

[14] Williamson and Welshans' complaints were consolidated by the state court on March 13, 2000.

On September 15, 2004, Plaintiffs filed a new complaint in the Circuit Court of Shelby County, Tennessee which was amended with a filing on September 20, 2004. In this second complaint, Plaintiffs reassert the claims averred in the dismissed action and seek judgment "three times the amount of their actual damages (including pre-judgment interest), which are to be determined at trial, or alternatively, their actual damages (including pre-judgment interest) plus the 25 percent penalty provided by Tenn. Code Ann. § 56-7-105, but limited to $74,999 exclusive of interest, costs and attorneys fees." (Amend. Compl. at 1.) Defendant removed the action to this Court with jurisdiction predicated on diversity of citizenship under 28 U S.C. § 1332. Before the Court is Plaintiffs' motion to remand the action back to the Circuit Court of Shelby County, Tennessee.

Removal of cases from state to federal court is governed by 28 U.S.C. § 1441(a), which provides that "any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending..." 18 U.S.C. § 1441(a) (1988). A federal district court has original jurisdiction over any civil action "where the matter in controversy exceeds the sum or value of $75,000, exclusive of interests and costs, and is between... citizens of different States." 28 U.S.C. § 1332(a) (2005). A defendant seeking to remove a case to federal court has the burden of proving that the jurisdictional requirements are met. See Gafford v. General Elec. Co.,997 F.2d 150, 155 (6th Cir. 1993) (citing Wilson v. Republic Iron & Steel Co., 257 U.S.

92, 97, 42 S.Ct. 35, 37, 66 L.Ed. 144 (1921)). The appropriateness of federal jurisdiction in a diversity case is determined at the time of removal. St. Paul Mercury Indem. Co. v. Red Cab Co., 303 U.S. 283, 293, 585 S.Ct. 586, 592, 82 L.Ed 845 (1938).

Plaintiffs concede that the parties are diverse, but contest that the amount in controversy exceeds $75,000. Because Plaintiffs specifically claimed less than the federal jurisdictional amount in their complaint, they contend that Defendant Aetna has not and cannot meet its burden of proving satisfaction of the amount in controversy requirement. Generally, the plaintiff, as the "master of the claim," may choose to claim less than the federal requirement in order to preclude removal from state court. See St. Paul Mercury Indem. Co., 303 U.S. at 294 ("If [the plaintiff] does not desire to try his case in the federal court he may resort to the expedient of suing for less than the jurisdictional amount, and though he would be justly enriched to more, the defendant cannot remove"). Accordingly, in states where plaintiffs cannot recover more than they pray for in their complaints, those who plead less than the jurisdictional amount may avoid federal jurisdiction.

However, where state counterparts to Federal Rule of Civil Procedure 54(c) enable a plaintiff to claim an amount lower than the jurisdictional amount in the complaint, yet seek and recover damages in excess of that amount, removal may be permitted if the defendant can show that it is "more likely than not" that the plaintiff's claims meet the amount in controversy requirement. Rogers v. Wal-Mart Stores, Inc., 230 F.3d 868, 871 (6th Cir. 2000) (citing Gafford,

997 F.2d at 158). The Tennessee Rules of Civil Procedure contain such a counterpart. Tennessee Rule of Civil Procedure 54.03 provides that, except in the case of default, "every final judgment shall grant relief to which the party in whose favor it is rendered is entitled, even if the party has not demanded such relief in the party's pleadings." Tenn. R. Civ. P. 54.03. Therefore, applying Gafford, Plaintiffs' choice of forum in Tennessee state court may be defeated if Defendant proves that their claims "more likely than not" exceed $75,000.

The amount in controversy is determined by the allegations in the complaint. National Nail Corp. v. Moore, 139 F. Supp. 2d 848, 850 (W.D. Mich. 2001) (citing Laughlin v. KMart Corp., 50 F.3d 871, 873 (10th Cir. 1995)). In their complaint, Plaintiffs allege that, as a result of Defendants wrongful acts in denying Welshans medical insurance claims during the period of 1995-2000, they have suffered damages in the amount of $74,999. (Amend. Compl. ¶¶ 5, 62, 73.) Plaintiffs further aver that they are entitled to recover treble the amount of actual damages pursuant to Tenn. Code Ann. § 47-18-109 and an additional twenty-five percent penalty on all sums recovered under Tenn. Code Ann. § 56-7-105. (Amend. Compl. ¶¶ 64, 74.) Calculating the relief requested using the damages suffered, the complaint asserts that Plaintiffs are entitled to recover up to $74,999 under Count I; $223,997 under Count II; and $93,748.75[15] under

---

[15] The twenty-five percent bad faith penalty on damages of $74,999 would amount to an $18,749.75 additional award for a total recovery of $93,748.75.

Count III. Based on this analysis, Defendant contends that Plaintiffs' complaint "expressly and affirmatively" seeks an award in excess of the jurisdictional amount." (Def.'s Resp. Pl.'s Mot. Remand ("Def.'s Resp.") at 2.)

Plaintiffs contest this conclusion on grounds that their prayer for judgment in the state court proceeding was specifically limited to $74,999 notwithstanding any allegations in the complaint entitling them to greater recovery. (Pl.'s Mot. ¶ 8.) In an effort to clarify the limitation, Plaintiffs stipulate "that they do not and will not seek or request judgment in the amount of $75,000 or greater, exclusive of interest and costs." (Pl.'s Mot. ¶ 8.) Plaintiff's stipulation in their Motion to Remand is of no effect as jurisdiction is decided as of the time of removal. Rogers, 230 F.3d at 873. Further, as noted above, Tenn. R. Civ. P. 54.03 permits plaintiffs to seek and recover more than that prayed for in the complaint. Rather than Plaintiffs' assertion of limited recovery, satisfaction of the amount in controversy requirement is determined by whether the values of the claims asserted in the complaint more likely than not exceed $75,000. Id. at 872.

As evidence that the values of the claims asserted in the complaint do not meet the jurisdictional requirement, Plaintiffs offer their "itemized list of unpaid claims and actual damages" totaling only $28,115 13. (Pl.'s Mot. ¶ 9 and Amend. Compt. Exhibit 4.) Plaintiffs also point out that the during trial in the previously dismissed action in federal court "it became apparent that plaintiff's recovery would be unlikely to exceed the $75,000 requirement for federal diversity jurisdiction." (Pl.'s Mot. ¶ 6.) However, even when these itemized damages are substituted for those

alleged in the complaint, the jurisdictional requirement is still satisfied as potentially trebling the amount results in an amount in controversy of $84,345.39. Further, the Court notes that the itemized damages are not final. Rather, Plaintiffs concede their belief that there may be additional claims for which they will seek recovery. (Amend. Compl. ¶ 41.)

The Court concludes that Defendants have met their burden of showing the amount in controversy more likely than not exceeds the requirement for diversity jurisdiction on the basis that, despite any limitation in their prayer for relief, state law may allow Plaintiffs to recover up to treble the $74,999 in damages alleged in their complaint as well as an additional twenty-five percent penalty. Consequently, Plaintiffs' Motion to Remand is DENIED.

IT IS SO ORDERED this 21st day of September, 2005.

/s/
J. DANIEL BREEN
UNITED STATES DISTRICT JUDGE

APPENDIX J

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TENNESSEE
MEMPHIS DIVISION

Case No. 04-2851-B V

[Filed December 7, 2005]

PEGGY WELSHANS WILLIAMSON and VANESSA WELSHANS, Plaintiffs,	)
v.	)
AETNA LIFE INSURANCE CO. Defendant.	)

NOTICE OF APPEAL

Plaintiffs, Peggy Welshans Williamson and Vanessa Welshans, by and through their lawyers, Rieves, Rubens & Mayton, hereby appeal to the United States Court of Appeals for the Sixth Circuit from the order of the district court dated November 16, 2005, and entered November 17, 2005, and the final judgment entered herein on November 21, 2005, which dismissed plaintiff's complaint, and all adverse orders and rulings, including without limitation the court's

order denying plaintiffs/appellants' motion to remand. There is no transcript to be ordered.

Respectfully Submitted,
RIEVES, RUBENS & MAYTON

/s/_____
Kent J. Rubens
Lawrence W. Jackson
Attorneys at Law
Post Office Box 1359
West Memphis, Arkansas 72303
(870) 735-3420

/s/ w/ permission KJR
Kathleen G. Morris
Attorney at Law
42 Rutledge Street
Nashville, TN 37210
(615) 242-3200

APPENDIX K

LEONARD GREEN
CLERK

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT
100 EAST FIFTH STREET, ROOM 540
POTTER STEWART U.S. COURTHOUSE
CINCINNATI, OHIO 45202-3988

MS. AUDREY CROCKETT
(513) 564-7032
(FAX) 564-7094
www.ca6.uscourts.gov

Filed: July 20, 2007

Mr. Thomas H. Gould
Western District of Tennessee at Memphis
167 N. Main Street
Suite 242
Memphis, TN 38103

RE: 05-6911
Welshans vs. Aetna Life Ins Co
District Court No. 04-02851

Dear Clerk:

Enclosed is a copy of the mandate filed in this case. The certified record was never sent to this Court on appeal.

Very truly yours,
Leonard Green, Clerk

/s/
(Ms.) Audrey Crockett
Case Manger

APPENDIX L

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 05-6911

[Filed July 20, 2007]

VANESSA WELSHANS;	)
PEGGY WELSHANS WILLIAMSON,	)
Plaintiffs - Appellants,	)
	)
v.	)
	)
AETNA LIFE INSURANCE COMPANY,	)
Defendant - Appellee.	)
	)

MANDATE

Pursuant to the court's disposition that was filed 3/22/07 the mandate for this case hereby issues today.

A True Copy.

COSTS:
Filing Fee . . . . . .$
Printing . . . . . $

Total . . . . . $

Attest:

/s/ _____
Deputy Clerk